THE lowdown

Health news, analysis and campaigns.
PILOT ISSUE #3
March 9 2019

Informing, alerting and empowering NHS staff and campaigners

Front line under pressure from cash squeeze

The number of patients waiting over 4 hours in A&E for a bed increased five-fold from 2012 (83,743) to 2018 (641,963).

But the pressures have continued to increase, and the final "sitrep" report for the 2018-19 winter shows only 20 out of 131 acute trusts managed to contain bed occupancy below 90% on March 3.

36 trusts were running on or above 97%, well above the already increased NHS England target level. Five were running completely full, at 100%

Of 13,400 patients brought by ambulance, 1,000 (7.5%) were kept waiting for over 30 minutes, and 129 over an hour to even get into the hospital.

The A&Es with most ambulance delays are Medway, Norwich, Newcastle, Tameside, Pennine Acute, Dudley, Grimsby, Worcester, Birmingham and Lincoln.

CCGs' cash crisis leaves Shropshire plan in chaos

Shropshire's already troubled NHS faces an escalating financial problem, combined with runaway growth in emergency admissions, even as health chiefs try to push through the closure of A&E services at Telford's busy Princess Royal Hospital – a move being challenged by Telford & Wrekin council.

Many other CCGs across the country will also be nervously grappling with the pressures of the coming financial year.

The situation facing Shropshire is revealed by a Medium Term Financial Plan published by Telford & Wrekin CCG in advance of their March Governing Body meeting It shows the area facing a financial gap next year of £50m.

Previously the CCG has always been getting by financially (unlike Shropshire, which is facing an £18.3m deficit for 2018/19 and will carry more than £60m cumulative deficit into 2019/20) .

There is also a huge increase in emergency/non-elective activity, which will not have been helped by axing the out of hours primary care services provided until last September by Shropdoc.

Emergency admissions

The T&W CCG paper shows A&E attendances are 9% above plan, ambulance conveyances 10% above plan, and emergency admissions a massive 16% above plan (and above 2017/18 activity levels). Shropshire's emergency admissions are also 5% above plan.

This means actual demand is already far greater than provided for under the highly controversial "Future Fit" proposals to scale down acute hospital services and "centralise" emergency services in Shrewsbury for the large rural county.

Emergency care is running above plan - A&E attendances by 9%, and emergency admissions by 16%

T&W CCG warns that the scale of the financial problem is so great it is beyond the scope of the CCGs to deal with it.

The target of £9.6m for 'QIPP' savings in the coming year is "higher than any QIPP that has been delivered in any previous year." It may well not be achieved: £4.2m of the £9.6m cuts have not yet been identified.

A third of the "savings" have to be made from acute sector, the Shrewsbury & Telford Hospitals Trust, which itself was already facing a projected £24m deficit this year, £5m above its control total.

The Future Fit plan hoped to deliver a marginal surplus of only £2.6m for the Trust, but this is ore than wiped out by the additional cuts from T&W CCG. Shropshire CCG also has to aim for cash savings from acute services, posing the Trust with even deeper financial problems.

It's now clear to all that the Future Fit plans don't add up either financially or in terms of demand and capacity.

The Trust is currently ranked 130 out of 131 for its performance on A&E services and on these new figures there is little hope of improvement.

Cllr Andy Burford, co-chair of the Joint Health Overview and Scrutiny Committee of Shropshire and Telford & Wrekin councils told *The Lowdown*:

"On the face of it these new CCG figures are very worrying.

"We have a JHOSC meeting coming up soon, and we will be asking some searching questions to establish what the real financial position is for health care in our area."

IN THIS PILOT ISSUE

WHO WE ARE – and why activists and campaigners need the Lowdown - Back page

PET-CT: Anger at Oxfordshire privatisation: but how many more to go? - 3

EXPLAINER: NHS fears of post Brexit tsunami of poor ex-pat pensioners 6 -7

COMMENT NHS England in no-man's land trying to escape 2012 Act 10-11

https://lowdownnhs.info/ contactus@lowdownnhs.info

UNISON mounts campaign against hike in professional fees

The Health and Care Professions Council (HCPC) is increasing its annual fees by 18% for members for 15 health professions.

The increase has been met with dismay by UNISON, the union representing many of the health care professionals affected, and by professional organisations, including the Chartered Society of Physiotherapy and the UK Association of Dieticians (BDA), that represent many of those registered with the HCPC.

UNISON has launched a campaign against the fee increase and are urging people to contact their MPs and ask them to sign the Early Day Motion 2069, which asks the HCPC to reconsider the increase.

UNISON notes that this rise means that the fees have increased by 40% since 2014. As well as the fee hike, the HCPC has also decided to remove discounts for new graduates.

The HCPC argues that the increase in fees is needed to make up for the loss of fees that will take place as social workers will no longer be registered by the HCPC from later this year.

As social workers under went the highest number of fitness to practice tests, then the HCPC will also lose money from this aspect of its work.

Registration with the HCPC is essential for members of 15 health professions, including physiotherapists, biomedical scientists, occupational therapists, radiographers, dieticians, and paramedics. Subject to parliamentary approval the fee increases will come into effect 1 October 2019.

UNISON reported that its survey of members registered with the HCPC found 99% did not agree with the increase, with more than 75% saying the HCPC does not provide value for money with the current fee. The union notes that the rise is completely disproportionate to wage increases in the NHS.

Professional bodies have also surveyed their members, including the Chartered Society of Physiotherapists, which found 90% of those that replied said no to the increase.

UNISON along with other professional organisations wrote an open letter to the HCPC in December 2018 arguing against the increase. Since then lobbying of MPs has taken place and a letter signed by 47 MPs has been sent to the HCPC.

The letter points out that the increase is "disproportionate to the current rate of inflation and fails to take account of the real terms wage freezes that many health staff have had to endure over the last few years."

In addition, the increase is likely to deter staff staying in their roles and new staff joining, in particular part-time workers.

The MPs called upon the HCPC to look at the way it works and improving its processes and procedures to save money, rather than increasing fees.

Care workers demand end to privatisation

Over three dozen care workers currently employed by private contractors Lifeways lobbied the Salford Labour Group and Salford City Mayor Paul Dennett on February 25, to demand their service is brought back in-house at the Council when the contract expires at the end of May.

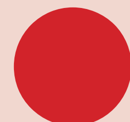
Lifeways has stated that it is not renewing its contract with Salford City Council, meaning other private companies will bid to take on the services and the workers.

After years of service in the private sector, the care workers are fed up with low wages, poor treatment and lack of investment in the support they deliver to vulnerable people.

UNISON Branch secretary Steve North told the ***Salford Star*** "There is no good reason why these workers should not be working directly for the Council or the NHS. The main expense is the wages and the Council and NHS already effectively pay those through existing contracts anyway. For us this is just a question of political will."

Labour prayer motion seeks to stop back door NHS changes

A 'prayer motion' sponsored by Jeremy Corbyn and six other Labour MPs has been tabled in the House of Commons in an attempt to prevent major changes being made to the current legislation on providing GP services without full Parliamentary scrutiny.



The contract leaves open the chance for private companies to take on the lead role

The changes are being introduced by the Department of Health and Social Care using Statutory Instrument 2019 No. 248 – The Amendments Relating to the Provision of Integrated Care Regulations 2019.

Changing legislation in this way means that MPs do not get the chance to debate or vote on the legislation.

The changes that will be introduced by the statutory instrument will be part of the new integrated care provider contract that NHS England is due to introduce in 2019 as part of its drive to convert all areas of England to integrated care systems.

The amendments will allow whichever organisation holds one of NHS England's new integrated care provider contracts to take control over the provision of primary care and directly employ GPs.

This means that a single organisation can hold a contract for all health care in an area - hospital, community and primary care.

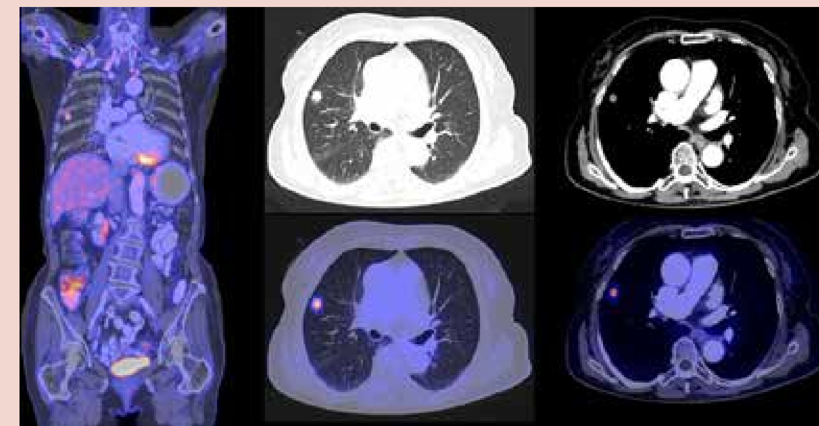
The contract leaves open the chance for private companies to take on the lead role, although a report by the Health Select committee judges that this looks unlikely in practice.

The prayer motion or NHS early day motion (EDM) No. 2103 is the only way to annul the changes before they take effect on 1 April 2019.

As of 5 March, the motion had been signed by 30 MPs, with the deadline for signing 24 March 2019.

Campaign groups, including 999 Call for the NHS, are urging people to lobby their MPs to sign the prayer motion, and has produced a template letter to send to MPs. 999 Call for the NHS is continuing its legal action against NHS England over the introduction of the integrated care provider contract.

PET project privatised – and how many more?



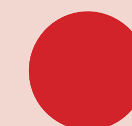
John Lister

In the week in which NHS England struck a pose as opponents of the compulsion to put services out to tender its junior officials were stonewalling questions from Oxfordshire campaigners angered at the imposition of a private contract for a high tech cancer scanning service.

The ***Banbury Guardian*** was the first to run the news that a 7-year contract to run Positron Emission Tomography (PET-CT) scanning services for the Thames Valley population (Oxfordshire and Buckinghamshire) had been awarded by NHS England not to the world-renowned experts at Oxford University Hospitals Trust, but to a private company, InHealth, that few will have heard of.

The OUH bid, backed by a large team led by a professor of nuclear medicine, failed to convince the management consultants (Arden GEM Commissioning Support Unit) running the procurement exercise on behalf of NHS England.

One consequence could be that the service will not be provided in the headquarters of the Trust's highly specialised cancer team at Oxford's Churchill Hospital, but elsewhere, in what one group of GPs have argued are "inappropriately converted buildings". This is likely to mean additional travelling and discomfort for patients



One consequence could be that the service will not be provided in the headquarters of the Trust's highly specialised cancer team at Oxford's Churchill Hospital

Lacking necessary staff

It could potentially also mean Churchill based staff might have to be relocated, since in a bizarre echo of Chris Grayling's disastrous effort to contract out post-Brexit ferry services to a company with no ferries, it appears that InHealth does not have the specialist radiographers necessary to deliver the service for which they have just been contracted.

To make matters even worse, NHS England failed to answer questions about the contract posed by the Banbury Guardian, but directed them to a web page referring to a defunct consultation that began and ended in 2016.

More digging reveals that the procurement of the PET-CT contract dates back to 2017, and the Thames Valley contract is one of 11 covering various areas of England, including three in London.

This procurement follows an earlier 10-year national contract that was initiated by the disaster-prone East of England Strategic Projects Team (which has since been disbanded, apparently handing the baton to the Arden GEM CSU).

At that stage the contract to provide PET-CT scanning services across 30 locations in England was won by the Collaborative Network headed up by Alliance Medical, a multinational corporation working with The Christie NHS Foundation Trust and some academic institutions: but this decision was not without controversy.

Concerns were raised by BuzzFeed News that in the 12 months prior to the deal two senior NHS bureaucrats were recruited by Alliance Medical, the Department of Health's "imaging technical lead" Phillip Webster and an NHS England "collaborating commissioner for PET-CT scanning" Mike Saunders. The fear was that this had given the company an edge.

BuzzFeed also revealed that any new scanners bought as part of the deal "will belong to Alliance Medical, not the NHS".

Suspicions were also aroused by the fact that while the tender had been issued for four separate contracts, Alliance Medical was awarded all four.

In Stoke on Trent the Royal Stoke University Hospital unsuccessfully challenged the decision to award the contract to Alliance Medical in preference to a bid from the local Trust and two other NHS Trusts that would have been £7m cheaper over 10 years.

More political pressure was needed for the successful fight against threats that the new service would mean Stoke patients having to travel for scans to Crewe, Birmingham or Liverpool, despite a modern scanner having been installed in their local hospital, largely funded by local donations.

Monopoly

Since then Alliance Medical, which secured itself a monopoly control of production of the isotopes used in the new scanners, has itself been bought up by a South African private hospital group Life Healthcare.

InHealth, which lost out on that contracting round to Alliance Medical, has been in business for 15 years and employs around 1,700 people, including clinical specialists and patient referral teams. Its services are provided from over 350 locations in the UK and Ireland, and they work with a significant majority of NHS Trusts in the UK covering over 200 hospitals and over 80 community health clinics.

But questions will continue to be asked on how they have been awarded the Oxford contract, why none of the NHS bodies in Oxfordshire were listened to, and whether patients will get the accessible, high quality service they would have received if the scanner was based in the existing NHS unit.

With a blanket of total secrecy surrounding this contract, and no news at all of the other 10 contracts tendered at the same time, this story has more chapters to come.

■ A profile of InHealth can be found online at The Lowdown's website.

New fight to save the Friarage Hospital

With Middlesbrough's James Cook Hospital taking to Twitter on March 7 to warn that patients with minor injuries would be in for "a long wait" because its A&E was struggling to cope, local campaigners are even more concerned at the imminent "temporary" closure of A&E at the Friarage Hospital in Northallerton.

The Friarage is a small hospital serving a rural population of 120,000, but faces a minimum 6-month closure from March 27, allegedly as a result of staff shortages, meaning the nearest alternative is the pressurised Middlesbrough hospital 23 miles away.

During the 6-month A&E closure it is to be replaced by a 24/7 "urgent treatment centre". Patients with more serious health needs will then have to be sent on to Darlington Memorial or James Cook Hospital – each around 30 minutes away.

The local Hambleton Richmondshire and Whitby CCG has accepted the closure, and decided to carry on with the planned public consultation on the future sustainability of services at the Friarage. Over 5,000 local people have already signed an online petition to Save the Friarage.

Mark Robson, leader of Hambleton council, told *NHS Executive* magazine that the permanent closure of the hospital felt like an inevitable "fait accompli".

One member of staff at the hospital also told the *Northern Echo* "It just seems as if it's death by a thousand cuts. The consultant led maternity unit went, mental health wards have gone, and it's as if there is this ongoing reduction in services."

Repeated battles have had to be fought to defend the hospital in the last 10 years, with a major demonstration in 2012 including Richmond's Tory MP at the time William Hague. He may be gone, but the fight goes on.

Prescription charges kill

The shocking story of the death of 19-year old waitress Holly Wolboys from asthma because she could not afford the prescription charge to replace her inhaler moved even the hard hearted news editors in the Daily Mail and the *Sun*.

Her case is an extreme one, but given that 2.3 million people in England have to pay for their daily asthma medication, and three quarters of them say they struggle to afford them, it is sadly unlikely to be unique.

But as the annual prescription price increase that hits patients in England on April 1 is set to take the cost per item to a staggering £9 for the minority of prescriptions that are paid for (almost 90% are dispensed free to people who are exempt – over 60, to children, to people on benefits, and to patients with epilepsy and diabetes).

England lags behind

In Wales, Scotland and the North of Ireland prescriptions are dispensed free to all, and the pressure is mounting from Asthma UK, pharmacists and anti-austerity campaigners.

A staggering 90% of patients on low incomes said they struggled to pay for their medication, a majority of them on zero hours contracts or making ends meet without any savings. Asthma is not the only condition that is much cheaper to control with medication than it is to treat emergency cases where it gets out of control putting life at risk.

Prescription charges in England are clearly raised more to make an ideological point and contain demand than for any rational reason.

Charges in 2017/18 added up to just less than £600m, just half of one percent of the budget of the Department of Health and Social Care, but they now stand as a major obstacle to improving the health of the working poor.

Sandra Gidley, chair of the Royal Pharmaceutical Society's English Board summed up the illogicality of the Westminster government's position when she told *Pharmacy Business*:

"The consequences of the relentless rise in prescription charges are well-known. If you can't afford your medicines, you become more ill, which leads to poor health and expensive and unnecessary hospital admission.

"Prescriptions are free in Scotland, Wales and Northern Ireland. It would be much simpler to have free prescriptions in England too, because then no-one would have to worry about payment decisions affecting their health."

■ More detail on this and a Q&A on prescription charges on our website.

CCG hires in an 'underperforming' firm

While NHS England tries to convince us all that they are aiming to integrate services, eager beaver privatisers like Bath and NE Somerset CCG (BaNES) clearly have other ideas.

From June 1 E-zec Medical Transport Services will take charge of these services in Bath and North East Somerset, Swindon, Wiltshire and Gloucestershire, "replacing the service currently provided by Arriva Transport Solutions".

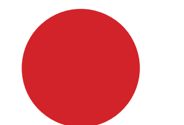
At the BaNES January Governing Body meeting the CCG enthusiastically reprinted in the company's description of itself as "a family run company focused on delivering high quality, safe, effective transportation for patients to and from a healthcare setting" – as they boast on their website.

CQC inspection

However a swift check on Google brings up some much less rosy assessments of the company, not least from last year's inspection by the CQC, which found the service was "underperforming in seven out of nine key performance indicators as of April 2018."

Vehicles checked were "unclean", with spilt liquids on seats and stretchers, "unsecured clinical waste on vehicles and a dirty, stained patient blanket behind a folded chair." Vehicle cleanliness was "not audited by local managers."

Mandatory training levels were below 50%, and the service did not have a structured plan with set actions to achieve compliance. "Staff morale was poor in areas; the culture of the service was one of fear to speak up. Staff team meetings were rare."



"The culture of the service was one of fear to speak up. Staff team meetings were rare."

In 2014, an investigation of their service in Dorset brought a damning report from local councillors that criticised E-zec's failure to arrive or late delivery of patients to hospitals for vital procedures like chemotherapy and dialysis.

For patients' sake let's hope the friendly family face of E-zec turns up, not the one seen by the CQC.

£270m cuts to include cancer care as CCGs prepare to merge

John Lister

Health workers and patients alike in Derbyshire will be bracing themselves for the worst, including cuts to cancer services, hip and knee replacements, as the county's four CCGs prepare to make more and deeper cuts as part of the conditions for merging into a single CCG.

According to the comparative figures drawn up by NHS Improvement's 'Right Care' initiative, Derbyshire is "overspending" against comparable areas by almost £48m, with the greatest variation in Musculoskeletal (£14m), followed by Respiratory (£7.6m), Circulation (£6.4m) and Cancer (£4.1m) – even though local cancer services are already missing most of their performance targets.

Main victims

So as local NHS chiefs desperately seek savings at any price, it seems the main victims will be users of these services, three of which are potentially life-threatening and one of which can leave patients denied treatment immobilised by chronic pain.

There is no hint of any compassion in the Medium Term Financial Plan rubber stamped by the "meeting in common" of the Governing Bodies of the 4 CCGs. It spelled out a dire future of repeated and deeper cuts in services. Despite apparent increases in funding things seem set to get worse if anything in the year from April, since the apparent new money is largely illusory:

"Of the 2019/20 allocation settlement a significant level relates to "Pass Through" funding – money that our Providers previously received through other sources and now receive directly from the CCG. … "The CCG's net real term growth in 2019/20 is therefore 0.16%, which taken together with the scale of our underlying deficit means that 2019/20 remains a very challenging year for the CCG."

Deficits

It charts an unbroken series of in-year deficits each year from 2017/18 (£80m); 2018/19 (£95m); 2019/20 (£98.5m); 2020/21 (£76.5m); 2021/22 (£50.4m) and 2022/23 (£34.1m). It notes that the "Commissioner Sustainability Fund" will cease to offer any relief from 2020, but hopes that QIPP "efficiency" savings will generate enough in 2022/23 to yield a small surplus.

For this year just ending the cuts target for 2018/19 was £51m, the magic figure that releases a £44m hand-out from the "Commissioner Sustainability Fund", and allows them to claim they have dealt with a total year's deficit of £95m.

Nonetheless the new Derby and Derbyshire CCG begins life next month with £61m of deficits carried forward.

Meanwhile the county's Sustainability and Transformation Partnership, now rejoicing in the jolly name of Joined Up Care Derbyshire has opted for sporadic publication of minutes from their closed Board meetings, which reveal the turmoil as the 2016 STP Plan has unravelled.

Back then the proposal was ambitious:

• Achieve a financially sustainable system: the combined impact of the priorities described will enable us to achieve a financially balanced health system by 2020/21. We will significantly change the 'shape' of the system:

• £247m more care "delivered through Place" (growing from 30% to 39% of all care delivered) and a reduction in care delivered in specialist settings

• Major changes to the workforce – 2,500 more staff delivering place-based care (c.10% of our current workforce)

• Reduction of bed-based care – 535 fewer beds (c.400 acute; 300 within Derbyshire system).

Hopes dashed

Clearly hopes of achieving the financial aims have been dashed: last September Joined Up Care discarded the targets for bed cuts, noting "It was recognised that the Derbyshire position has changed significantly since the completion of the original STP plan and therefore there was a need to revisit the assumptions around bed numbers."

It was agreed to commission yet more management consultancy (Newton Europe) to advise on how to move forward from the essentially useless plans drawn up by another (Oak Group) for the STP, which had assumed "the community" could absorb thousands of patients.

The financial burden on the health care system of the £00m-plus PFI contract at Royal Derby Hospitals remains unresolved.

Cancer cuts

No details have yet emerged on how the cutbacks in cancer care and other services are to be carried out without immediate and disastrous consequences. Less than half of the £69.5m of cuts needed next year to hit the "control total" has been identified.

Finance chiefs apparently argue "we can no longer afford to commission all current services at the same level" – so tough luck if you need cancer care or a joint replaced.

Nor is it clear what the implications are for staff, although a governing body member from North Derbyshire told the *Derby Telegraph* he feared they will "struggle", while the chair of Erewash CCG was hoping to be able to alter staff roles, arguing that "We need a bit more flex to help our workforce to work differently".

The Turnaround Director for the 4 CCGs, Sandy Hogg was looking to secure "more agile working."

That kind of comment is not likely to help win the trust or affection of hard pressed health workers caught in a crisis that is none of their making.

NHS faces fears of post Brexit tsunami of poor expat pensioners

John Lister

Debate over a short enabling Bill in Parliament to give ministers legal powers to fund and implement healthcare deals after Brexit has highlighted a number of major concerns.

And with even optimistic estimates of a possible influx of at least 190,000 British migrants looking to the NHS for their treatment in the event of a no deal Brexit, the stakes are high.

The official line is that the Healthcare (International Arrangements) Bill "seeks to safeguard healthcare for expats and 50 million people who travel abroad every year, through agreements with the EU or member states."

The Department of Health and Social Care argues the Bill "will establish the legal basis to fund and implement reciprocal healthcare schemes and share necessary data after we leave the EU."

But questions have been raised by Labour on the actual numbers of people involved: according to Shadow Health Minister Justin Madders, DWP statistics show more than twice as many – up to 469,000 UK pensioners – might be living in the other 27 EU countries. In debate on the second reading he said:

"Some clarity from the Minister would be appreciated, because the impact assessment appears completely to underestimate the complexity and cost of implementing what might end up being a diverse array of agreements.

"When they gave evidence to the House of Lords European Union Committee, the British Medical Association and the Royal College of Paediatrics and Child Health were clear that should no EU-wide reciprocal agreement be achieved, the significant costs of establishing bilateral reciprocal arrangements with EU and EEA countries would fall on the NHS."

British migrants

Justin Madders went on to underline the extent to which care of ageing British migrants is currently undertaken by health services in the EU:

"Expenditure on UK state pensioners and their dependants accounts for approximately 75% of the total amount that we spend on reciprocal healthcare and supports UK state pensioners and their dependants living in Europe. In 2016-17, that equated to an estimated £468 million.

"The Department for Health and Social Care has accepted that the system is extremely cost-effective for the UK, not least because treatment overseas is often cheaper than it is in the UK. For example, Spain's latest average pensioner cost is €4,173, compared with £4,396 in the UK."

The returning pensioners could require around 900 extra NHS beds, and cost in excess of £1 billion – more than double the current UK payments

Back in 2017 the Commons Health Committee was warned that if after a no-deal Brexit the UK ceased paying for the health cover for ex-pat pensioners with pre-existing health problems, many of them would be unable to afford private insurance.

Their host country would not have any obligation to support them, since they have not contributed to their health and social security system.

Low incomes

Many British retirees living abroad have low incomes, and with a likely collapse in prices for many properties in Andalusia and similar areas if many are forced to return to Britain, they would arrive back "in poverty".

The Nuffield Trust has estimated that the returning pensioners would require around 900 extra NHS beds, and cost in excess of £1 billion – more than double the current UK payments.

Figures in the Commons Library Briefing Paper on the Bill show that the UK paid out £630m to cover costs of UK patients treated in the European Economic Area, 75% of them pensioners, and almost 90% in the main centres of UK migration, Spain, Ireland, and France.

By comparison the UK claimed back just £66m for the health care of EEA citizens. The ten-fold disparity, as Sarah Wollaston pointed out, is largely down to the much larger numbers of British pensioners and citizens choosing to live in EU countries than EU residents seeking to live in Britain.

In the event of a no deal scenario, the UK Government may need to rely on the powers of the Bill to implement new bilateral agreements with individual Member States from 29 March 2019

Given the extremely limited success on negotiating other aspects of British withdrawal and the weak negotiating position of a no-deal situation, there are reasons for concern.

The Library Briefing notes that what has so far been agreed centres on protecting the entitlements of people who are already living, working or travelling in the EU on exit day: this does not address many of the longer term questions once freedom of movement has been repudiated.

"The Health Committee's 2017 report on Brexit and health and social care reported that, if no deal is agreed, in some cases British insured people in other member states will retain entitlement to some aspects of healthcare via the domestic legislation of the countries in which they are resident.

"The UK hope that member states will be willing to support UK nationals to access healthcare"

However, the Committee noted that such rights would 'be by no means universal and enforcement of entitlements is likely to be problematic'."

It goes on:

"The UK hope that member states will be willing to support UK nationals to access healthcare and the Bill will support us to implement bilateral agreements that would help do this.

"However, in the absence of any agreements a reasonable working assumption is that member states will apply the same rules to UK nationals that they apply to 3rd country nationals."

The report flags up the uninspiring collection of 16 countries with whom the UK has an established bilateral healthcare agreement: with the exception of Australia and New Zealand these are mainly small, often island countries with small numbers of British visitors:

Anguilla; Australia; Bosnia and Herzegovina; British Virgin Islands; Falkland Islands; Gibraltar; Isle of Man; Jersey; Kosovo; FYRO Macedonia; Montenegro; Monserrat; New Zealand; St. Helena; Serbia; Turks and Caicos Islands

This looks like a restrictive list of potential holiday destinations and retirement spots: we are yet to see any compensating benefits from the chaotic Brexit process.

Bill would give ministers sweeping powers

There are also concerns over the scope of the Bill, which was first moved in the Commons last autumn and will reach its Report Stage in the Lords on March 12. The Briefing Paper on it produced by the House of Commons Library points out that the Bill

"does not propose any specific healthcare arrangements, it simply gives the Government the power to bring in a new reciprocal arrangement or make payments."

Parliamentary debates on the Bill have centred on ministers' increased use of 'statutory instruments' to introduce legislation without adequate scrutiny.

From the cross benches, Lord Judge made the telling point that it is "exactly 40 years" since the Commons rejected a statutory instrument – suggesting a commemorative stamp might be printed.

Another cross bencher, Lord Hope gave an example of the vagueness of the Bill, which has just six clauses:

"On page 3 of the Bill at line 40, we are asked to approve Clause 5(3), which allows regulations to be made amending, repealing or revoking, 'primary legislation … for the purpose of conferring functions on the Secretary of State or on any other person'."

He asked: "I can understand conferring powers on the Secretary of State, but why "on any other person"?

Lord Patel quoted the criticisms of the Delegated Powers and Regulatory Reform Committee, which said in its report: "The Minister does not give any indication of what primary legislation might in future need to be amended".

Baroness Thornton, Labour's leader in the Lords argued that "the Bill as drafted breaks all the rules of our constitutional understanding."

In the Commons Shadow Health Minister Justin Madders also quoted the Delegated Powers and Regulatory Reform Committee, and its description of the powers in Clause 2 as "breathtaking".

In another Commons debate he pointed out that:

"The Bill gives the Secretary of State wide-ranging powers, including the power to amend primary legislation through a Henry VIII-style clause, but it places no obligation on the Secretary of State to report back to Parliament, even in the event that a reciprocal deal cannot be reached."

He went on:

"Where are the checks and balances if the NHS ends up having to police 27-plus different sets of arrangements? What if the deals reached end up costing far more?

"What if our cost recovery continues to lag well behind what it should be? There needs to be greater parliamentary oversight of all these issues."

New pressure to charge visitors for NHS care

Unfortunately the debate on the Bill has also highlighted a worrying apparent parliamentary consensus in favour of NHS trusts being more aggressive in levying charges for treatment on people from overseas. Labour's Justin Madders is quoted In the Commons Library Briefing complaining that:

"irrespective of Brexit, it is deeply concerning that millions of pounds that should be spent on UK patients by the NHS is going to waste because of a failure to get a grip on cost recovery".

As a result of Tory legislation in 2015 and 2017 accompanying the "hostile environment" for migrants (and linked with hugely inflated claims on the scale of so-called "health tourism,") a new legal duty was placed on NHS staff to charge people not resident in Britain for treatment, despite concerns raised by the medical profession and health workers.

More to be collected

In debate on the Bill's second reading Mr Madders called for more charges to be collected:

"In 2012-13, the NHS charged only about 65% of what it could have done to visitors from outside the EEA and Switzerland, and only 16% of what it could have done to visitors from within that area.

"I accept that things have improved since then, and that the Department set itself a recovery target of £500 million overall and £200 million for EEA and Switzerland patients, which it hoped to achieve by 2017-18, but it still appears to be well behind on those targets.

"I would therefore be grateful if the Minister could advise us on the latest projections for that."

However the impact this could have on the ethos of the NHS as a system that prides itself on providing care free at point of use was illustrated in the same debate by Poole Tory MP Robert Syms.

He is eager to compel hard-pressed and dedicated staff in A&E to focus more on cost recovery than patient care:

"We have to emphasise to trusts the requirement to recoup money, because that means more money for British people using the service and for other services, but sometimes it falls down the priority list.

"I am not sure there is a magic bullet. It probably requires drilling lots of people in A&Es up and down the land to focus on whether people should be paying or getting free treatment."

The NHS is still trapped in Tory no-man's land

Paul Evans

Nearly seven years ago the coalition government introduced the biggest ever set of changes to the NHS. Now NHS England wants to undo large parts of that legislation.

The Health and Social Care Act was driven through Parliament despite a hail storm of opposition. This week plans were published calling on the present government to introduce fresh legislation.

However, this major shift in policy could be mired because the government lacks the necessary Parliamentary brawn, leaving the NHS in a dangerous hinterland.

NHS England already have skin in the game. At the start of the year they published their Long-term plan - an ambitious 10-year vision to bring councils, hospitals, GPs and non-NHS providers together, to organise healthcare in new local partnerships, breaking down all the old barriers. It was all launched with bold promises to save 500,000 lives and transform our health care.

NHS England CEO Simon Stevens knows that success rests on some critical elements that are not directly within his control.

Solving the workforce crisis needs further funding and a more open immigration policy.

A solution on social care has been ducked by governments for decades. A third crucial piece is the need to reorganise the NHS.

Of course, it won't be called a reorganisation, as part of the fallout from the last NHS shake up is that the service has an understandable aversion to more change. But NHS England has already started the process, by instructing each area to form one of 42 integrated care systems (ICS) – new partnership boards made up of key organisations and providers.

Yesterday's ideas

The once radical ideas behind the Health and Social Care Act are being overwritten. They are at odds with NHS England's new era of integration.

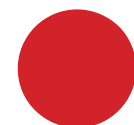
NHS leaders are now trying to pull health bodies out of their competing silos, confronting the fragmentation that has predictably emerged from forced competition, but there is a problem. The laws and structures behind the market mayhem are still in place.

NHS England say they can achieve changes without Parliament, but they are clear about their preference for primary legislation and believe that "legislative change could make implementation easier and faster."

However, the last election left the government with a majority too small for the average park kick about. Ministers know that to put new NHS legislation through Parliament would need a host of steely defenders to see off a barrage of unwelcome amendments.

This explains why the promise made in the 2017 Conservative Party manifesto to put new NHS legislation before Parliament has already been quietly dropped.

No surprise then that this week that unofficial comments reported on Twitter, from a "government source" to a well-placed journalist, appeared to firmly dismiss any prospect of new legislation.



The once radical ideas behind the Health and Social Care Act are being overwritten

So what's plan B? NHS England claim that much of what they want to do can be done without legislation.

On competition, they can remove the obligation for NHS contracts to go out to tender quite easily by revoking the regulations without Parliament's help – but the NHS is also caught by EU public contract law.

Finding a route around this largely depends on the outcome of Brexit, according to Andrew Parker a procurement specialist and partner at Hempsons.

Deal means EU law

He concludes that signing a version of May's deal would keep us under EU law for the whole of the transition period.

Staying in a version of a customs union would mean that procurement rules would stay the same. 'No deal' would separate us from EU public contract law, but that there would still be a need for other legislation to replace it.

This is a complex landscape and in bypassing Parliament it is becoming clear that all manner of compromises, temporary patches, accountability workarounds and governance issues will emerge.

Without a change in law Clinical Commission Groups remain the lead player in terms of the current legislation, but the new integrated structures demand that they hand over control to a new local partnership board.

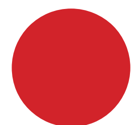
The plan may be to give NHS foundation trusts the power to create joint committees as the basis for the 42 new integrated care systems (ICSs), but how will they work, who is in charge and how are they accountable?

No legal powers

John Coutts, policy adviser to NHS Providers and a governance specialist has exposed some of the risks in NHS England's Plan B.

"The partnership 'boards' proposed in the long-term plan to lead integrated care systems (ICSs) are not bodies corporate.

"They have no legal powers to make decisions and rely on delegations and committees in common to make decisions. This means that there can be no binding majority decision making which can lead to lack of clarity about when a decision has been made and by whom"



Without a change in law Clinical Commission Groups remain the lead player in terms of the current legislation

It is clear that the existing market-based structures will be stretched and pushed in ways that were not intended, and there is an unresolved legal debate amongst policy makers about how far they can go.

For all the current public disquiet with Parliament, its role in scrutinising proposed changes to complex systems like the NHS would be reassuring in this situation.

The government may opt to circumvent MPs, the Lords and all their committees and process, but with that we are depriving ourselves of some our democracy's built-in safeguards.

There is already concern that the government is abusing its powers by making changes through statutory instruments and avoiding Parliamentary discussion. The Labour leader recently launched a motion, known as a Prayer to object to this tactic being used to adjust the relationship between GPs and the new ICSs (see p2).

The need for scrutiny is also highlighted by NHS England's plan to introduce powers that will force foundation trusts to merge. This move suggests that local democracy will once again be trumped by those at the top of the NHS. And worryingly it flies in the face of all the evidence about the success of past mergers.

Research by the University of Bristol on the impact of 102 acute hospital mergers from 1997 to 2006 found that productivity didn't improve, waiting times increased and so did the debts of merging trusts. Similar negative conclusions were reached in a study of mergers between 2010-15 by the Kings Fund, work which also showed that improvements in care such as to stroke and cancer services have been achieved through cooperation without the need for mergers.

Campaigners will be worried that new mergers will be cover for a host of cost-driven decisions aimed at reducing debt and cutting services rather than boosting them.

Personal health budgets

In a similar vein NHS England's plan to expand personal health budgets in the NHS needs proper public dissection. Giving patients a set sum for their care and allowing them to choose how it is spent is a high risk policy that has already been heavily criticised.

What happens when the funds run out, patients will feel the pressure to top-up from their own pockets, but many will not have the means. Is this rationing by the backdoor or more charging by the front?

Equally, combining health and social care could be beneficial, but it is full of potential traps.

Healthcare must remain free at the point of use and not means tested like social care.

How too can we develop a new army of community-based health professionals without a commitment for them to work for NHS organisations and not in the private sector?

The implementation document from NHS England does give cheer to those who have been battling against the marketisation of the NHS. However, it also provokes concern that by not enshrining these hugely significant changes in primary legislation, controversial and flawed plans will proceed unchallenged.

It proves that to defend the NHS against damaging ideas and to promote the best, we need more democracy, transparency and accountability, not less, both at the heart of our NHS structures and in our wider society.

Curate's egg of NHS England proposals to change the law

John Lister

The joint board meeting of NHS England and NHS Improvement on 28 February discussed the primary legislative changes for the NHS referred to in the NHS Long Term Plan.

This follows a powerful campaign involving many parties and methods to expose the risks and intent behind 'Accountable Care Organisations' and the ACO contract that was to have been introduced by April 2018

The proposals perhaps predictably opt not to follow the route suggested by the NHS Reinstatement Bill.

However it's clear that important changes are being proposed, even if the primary focus of the NHS England proposals is "to make it much easier to integrate services."

Two key measures are not mentioned by NHSE/I:

- reinstating the duty of the Secretary of State to provide or ensure a comprehensive, publicly-provided NHS is available, free at point of use and funded through general taxation.
- restoring the accountability of NHS England to the Department of Health (and thus to the Secretary of State and through that office to parliament and the electorate).

Both of these are necessary to restore proper accountability at national level. However some of the proposals that are listed are definitely positive.

Disintegration

Campaigners have always opposed the *dis*-integration of services driven by the "internal market" from 1991 and contracting and the competitive market since 2000, which were entrenched and deepened by the 2012 Health and Social Care Act.

While campaigning for better integrated delivery of care, we focus on the literal meaning of the word "integration" rather than NHS England's use of it as shorthand for organisational integration, "Integrated Care Systems" and the controversial "Integrated Care Provider" contract, which most campaigners would not accept.

Nor do we think the Competition and Markets Authority has any legitimate role in the NHS or public services, campaigners will ***oppose*** NHSE/I being given statutory rights to impose mergers of hospitals/services, and to bypass full public and parliamentary consultation.

End of Section 75?

However there seems to be no sensible reason why campaigners who fought to prevent the 2012 Health & Social Care Act ever going through would now want to keep some of the most controversial clauses that have led to the carve-up of the NHS into contracts and a competitive market.

So there is no reason to oppose NHSE/I's proposal that: "We propose that the regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed."

We don't support 'Integrated Care Systems': but if NHSE/I, in preparing for these, are talking of mergingcommissioners and providers, we should call for legislation to do this properly, and create new Health Boards as **public bodies**, meeting in public, publishing board papers, subject to FoI requests, and bringing in elected council members, trade union and lay reps?

That's the kind of integration we want. So while the Lansley Act is being dismantled, let's not miss what could be a chance to press for our alternative.

Council joins challenge to Kent & Medway stroke centralisation

John Lister

The battle over the future of Urgent Stroke Services continues in Kent and Medway, even after a unanimous decision of the Joint Committee of Clinical Commissioning Groups on February 14 to nod through a controversial plan to centralise services in new specialist units in Maidstone, Dartford and Ashford.

Each of the "Hyper Acute Stroke Units" are also supposed to have an acute stroke unit to give patients expert care after the first 72 hours until they are ready to leave hospital, and a clinic for assessing and treating transient ischaemic attacks (TIAs or mini strokes).

Medway is one of the four hospitals that now stands to permanently lose its existing stroke services when the HASU/ASUs are developed: the others are Tunbridge Wells Hospital; Queen Elizabeth, the Queen Mother Hospital in Margate; and Kent & Canterbury Hospital (where services are already "temporarily closed").

Medway Council has confirmed that it will seek a judicial review of the decision. The council has cross-party agreement to allocate £50,000 towards the cost of the challenge. Medway is about 12 miles by road (30 minutes in light traffic) from Maidstone, and 18 miles down the A2 from Dartford: these journey times increase at peak times of congestion, which delay even blue light ambulances.

No local care

Medway's Conservative leader Cllr Alan Jarrett told *Kent Online*: "I am deeply concerned by this decision, especially as Medway Maritime Hospital is the local hospital for more than half a million people across Medway and Swale. When these changes happen, if any of them have a stroke they and their families will no longer be able to receive care locally."

Even longer journeys are on the cards for stroke patients from Margate: from there to William Harvey Hospital in Ashford is around 40 miles, an hour's journey by car at off peak times, while the other alternative, Maidstone, is five miles further away.

Journeys from Tunbridge Wells to Maidstone are around 20 miles (40 minutes in light traffic). In each case public transport options for relatives wishing to visit take even longer.

The business case document argument for the centralisation of services admits that "There was also some challenge and criticism," and concedes that "some people must travel further to access acute stroke services," but claims "this will be more than offset by the improvement in clinical quality from the introduction of HASU/ASUs."

Concerns over statistics

Yet campaigners have highlighted a number of concerns over the way the case has been argued and the statistics that have been used, which rely heavily on claims of numbers of lives saved by centralising stroke care in London.

The Business Case also points to the danger that one or more of the existing units could close even before the new services come on stream

These figures take no account on the number of lives that might have been lost as a result of increased delay in reaching hospital from areas where local services had closed down: and of course journey distances and travel times in Kent are much longer than London.

There are concerns about capacity of the new system: the plan involves a permanent 16% reduction in bed numbers for stroke patients, from 154 at present to 129: although 24 of these beds are already effectively closed by the "temporary" closure of stroke care at Kent & Canterbury, it's clear the system will not be expanded despite the growing population..

Each of the three new centres will require additional beds to handle the extra caseload, with Maidstone and William Harvey Hospital more than doubling their current bed numbers.

London patients

In its robust challenge to the stroke service plans, Medway Council warned of the danger that patients from South East London could wind up using a growing share of the remaining beds, especially in Dartford.

Medway is the largest and fastest growing urban area outside London: "the location of the HASUs outside of Medway will increase health inequalities".

Medway's response goes on to quote the Clinical Senate's warnings on the likely pressures on the centralised stroke services, which "suggested that the increasing proportion of elderly people in Kent and Medway together with the increase in the overall population is 'likely to result in an actual rise in the total number of stroke cases per year, even if the age-related stroke incidence remains the same'."

Nor is it guaranteed that a centralisation will raise performance as promised. Comparative figures in a recent report on similar centralisation in Manchester reveal that many of London's performance figures on stroke, even after its expensive centralisation, are not even in the top quartile of stroke units.

Indeed some Kent services, including the potentially doomed QEQM in Margate, are already outperforming London on access to imaging within an hour of admission.

Worryingly, the Business Case also points to the danger that one or more of the existing units could close even before the new services come on stream, or as they put it: "the risk of closing units becoming unsustainable due to an inability to retain and recruit staff".

This risk is of course multiplied many times over by the blight that will inevitably fall on the doomed stroke units now it is clear they will close in a couple of years at most.

Health campaign group Save Our NHS in Kent claim staff are already leaving QEQM. Spokesperson Carly Jeffrey told the *Isle of Thanet News*:

"SONIK has been told that since staff at QEQM's stroke ward were issued documents about their future employment, a number of skilled nurses have found new jobs elsewhere, as they were not able to move to Ashford. EKHUFT appears to have effectively decimated their own workforce at a time of national shortages. These are people with specialist skills and experience. We are told only two nurses from the stroke ward are willing to move to Ashford."

The changes have been under debate for five years: if they are not held up by the judicial review (or staff shortages) they will move into the implementation phase. The CCGs anticipate that the new stroke service will begin at **Maidstone** and **Darent Valley** hospitals in about a year's time, and at **William Harvey** Hospital in spring of 2021.

US aiming to use trade deal to lever open the NHS says new analysis

The US administration have announced its objectives ahead a new post brexit trade deal with the UK. An analysis by the People's Vote organisation focuses on the impact upon the NHS. It is warning that they could lead to higher prices for the NHS and a relaxing of the rules surrounding who has access to patient data held by the NHS.

Peoples Vote see significant dangers within a key section relating to "Procedural Fairness for Pharmaceuticals and Medical Devices". The objective states;

"Seek standards to ensure that governmental regulatory reimbursement regimes are transparent, provide procedural fairness, are non-discriminatory, and provide full market access for U.S. products."

Peoples Vote, which favours another referendum, believe that this implies that the US will seek to open up the UK market to US-style direct marketing of drugs and remove restrictions on drug pricing.

Labour MP, Jo Stevens, a supporter of the People's Vote said:

"Donald Trump's administration has now made it clear just what it will be demanding from the UK in return for a trade deal - and one of those things is that we let big US companies run riot in the NHS.

"One demand of the US is that the NHS pay more to US drug companies and that that US drug companies… get full access to the NHS – long a demand from US mega-lobbyists in the pay of Big Pharma."

The analysis echoes some of the concerns of a group of academics who published their view last year, but who were also concerned that there would be little chance to amend the deal. Professor Tamara Hervey, University of Sheffield, said

"While deals have to be ratified by Parliament, Parliament cannot amend the agreement that the Government negotiates, or be directly involved as the negotiation takes place."

Responding to campaigners' concerns in the TImes, Liam Fox said he would protect the NHS in any future trade talks and was "unsurprised" by the US stance.

The release of the negotiating objectives confirms a statement of intent made by the President Trump in May 2018 that he will always "put american patients first" and put a stop stop to other countries "free loading" which he blamed for higher drug prices in the US.

Trump said: "as we demand fairness for American patients at home, we will also demand fairness overseas. When foreign governments extort unreasonably low prices from US pharmaceutical companies, Americans have to pay more to subsidise the enormous cost of research and development".

A particular target for criticism by the Trump administration was single-payer healthcare systems, such as the NHS, which impose drug price controls. He accuses foreign governments of not paying their fair share of research and development costs to bring innovative drugs to market.

One US demand is that the NHS pay more to US drug companies

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

The Lowdown launched earlier in February 2019 with our first 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, and undertake investigations and research that other organisations aren't able to take on.

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 issues 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