In this issue

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

JOHNSON
Can the front-runner as next PM be trusted with our NHS? - 6-7

NHS England plan
Stand by for a new round of rushed secret plans as in 2016 4

ANALYSIS
BED SHORTAGE forces NHS to look to private sector 8-9

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

Informing, alerting and empowering NHS staff and campaigners

Birmingham & Solihull staff united against WOS
Dozens of NHS porters, housekeepers, domestic assistants and maintenance staff at Birmingham and Solihull Mental Health Foundation Trust, who face being transferred to a wholly owned subsidiary (WOS) staged three days of solid strike action on 24-26 June (pictured right).

The strike, which was officially backed by Unite and UNISON followed a 92% vote for action against being transferred to a ‘wholly owned company’, Summerhill Services Ltd from 1 July.

Bradford strike to stay 100% NHS
UNISON members in Bradford Teaching Hospitals NHS Foundation Trust are bracing for a 7-day strike as we go to press.

They are fighting to stop 600 estates, facilities and clinical engineering staff being transferred out of the NHS into a “wholly owned company.” The ballot recorded a 97% vote for action.

Meanwhile trust management have admitted that £13m of the claimed £28m ‘efficiency savings’ from the scheme over 5 years would be from reduced VAT payments. This appears to run counter to the guidance from NHS England and the Treasury, which has warned that “tax avoidance arrangements should not be entered into under any circumstances.”

The trust denies the proposal amounts to privatisation: but staff would no longer be employed by the NHS, but directly employed by this “NHS-owned company” – which the trust claims would have a 25-year contract.

Halted: plans to privatisse urgent care in Halton

Paul Evans
NHS staff, campaigners and the local MPs are celebrating after Halton CCG announced it was backing away from plans to award a £25m contract to run two urgent treatment centres to a private firm.

The centres in Widnes and Runcorn are currently run by two NHS trusts, Warrington and Halton Hospitals Foundation Trust and Bridgewater Community Healthcare Foundation Trust.

The HSJ reported that a private company – One Primary Care, had been made the preferred bidder prompting one of the NHS providers to threaten a legal challenge.

Local GPs, who were part of the bid had raised their concerns about the plans to outsource services alongside objections from the local MPs, unions and local campaigners.

Halton CCG is understood to have abandoned the procurement after considering the responses and the potential delays and costs involved in defending the decision. The HSJ reported that One Primary Care are not considering their own legal action, but the CCG has not confirmed future arrangement beyond saying that they will continue with the current NHS providers in the short term.

Local MP Mike Amesbury, who joined a protest of UNISON members outside the one of the centres in Widnes told the Liverpool Echo “This is an important victory and just goes to show what can be achieved when we all work together to fight for our NHS.”

Mr Amesbury asked Health Secretary Matt Hancock if privatising the Runcorn UCC was part of his plan.

Mr Hancock’s enigmatic reply was: “The most important principle at stake is how to deliver the best possible services for our constituents”.

Evasive on privatisation – Hancock

Local GPs had raised concerns about the plans

Paul Evans
NHS staff, campaigners and the local MPs are celebrating after Halton CCG announced it was backing away from plans to award a £25m contract to run two urgent treatment centres to a private firm.

The centres in Widnes and Runcorn are currently run by two NHS trusts, Warrington and Halton Hospitals Foundation Trust and Bridgewater Community Healthcare Foundation Trust.

The HSJ reported that a private company – One Primary Care, had been made the preferred bidder prompting one of the NHS providers to threaten a legal challenge.

Local GPs, who were part of the bid had raised their concerns about the plans to outsource services alongside objections from the local MPs, unions and local campaigners.

Halton CCG is understood to have abandoned the procurement after considering the responses and the potential delays and costs involved in defending the decision. The HSJ reported that One Primary Care are not considering their own legal action, but the CCG has not confirmed future arrangement beyond saying that they will continue with the current NHS providers in the short term.

Local MP Mike Amesbury, who joined a protest of UNISON members outside the one of the centres in Widnes told the Liverpool Echo “This is an important victory and just goes to show what can be achieved when we all work together to fight for our NHS.”

Mr Amesbury asked Health Secretary Matt Hancock if privatising the Runcorn UCC was part of his plan.

Mr Hancock’s enigmatic reply was: “The most important principle at stake is how to deliver the best possible services for our constituents”.

Paul Evans
NHS staff, campaigners and the local MPs are celebrating after Halton CCG announced it was backing away from plans to award a £25m contract to run two urgent treatment centres to a private firm.

The centres in Widnes and Runcorn are currently run by two NHS trusts, Warrington and Halton Hospitals Foundation Trust and Bridgewater Community Healthcare Foundation Trust.

The HSJ reported that a private company – One Primary Care, had been made the preferred bidder prompting one of the NHS providers to threaten a legal challenge.

Local GPs, who were part of the bid had raised their concerns about the plans to outsource services alongside objections from the local MPs, unions and local campaigners.

Halton CCG is understood to have abandoned the procurement after considering the responses and the potential delays and costs involved in defending the decision. The HSJ reported that One Primary Care are not considering their own legal action, but the CCG has not confirmed future arrangement beyond saying that they will continue with the current NHS providers in the short term.

Local MP Mike Amesbury, who joined a protest of UNISON members outside the one of the centres in Widnes told the Liverpool Echo “This is an important victory and just goes to show what can be achieved when we all work together to fight for our NHS.”

Mr Amesbury asked Health Secretary Matt Hancock if privatising the Runcorn UCC was part of his plan.

Mr Hancock’s enigmatic reply was: “The most important principle at stake is how to deliver the best possible services for our constituents”.

Paul Evans
NHS staff, campaigners and the local MPs are celebrating after Halton CCG announced it was backing away from plans to award a £25m contract to run two urgent treatment centres to a private firm.

The centres in Widnes and Runcorn are currently run by two NHS trusts, Warrington and Halton Hospitals Foundation Trust and Bridgewater Community Healthcare Foundation Trust.

The HSJ reported that a private company – One Primary Care, had been made the preferred bidder prompting one of the NHS providers to threaten a legal challenge.

Local GPs, who were part of the bid had raised their concerns about the plans to outsource services alongside objections from the local MPs, unions and local campaigners.

Halton CCG is understood to have abandoned the procurement after considering the responses and the potential delays and costs involved in defending the decision. The HSJ reported that One Primary Care are not considering their own legal action, but the CCG has not confirmed future arrangement beyond saying that they will continue with the current NHS providers in the short term.

Local MP Mike Amesbury, who joined a protest of UNISON members outside the one of the centres in Widnes told the Liverpool Echo “This is an important victory and just goes to show what can be achieved when we all work together to fight for our NHS.”

Mr Amesbury asked Health Secretary Matt Hancock if privatising the Runcorn UCC was part of his plan.

Mr Hancock’s enigmatic reply was: “The most important principle at stake is how to deliver the best possible services for our constituents”.

Paul Evans
NHS staff, campaigners and the local MPs are celebrating after Halton CCG announced it was backing away from plans to award a £25m contract to run two urgent treatment centres to a private firm.

The centres in Widnes and Runcorn are currently run by two NHS trusts, Warrington and Halton Hospitals Foundation Trust and Bridgewater Community Healthcare Foundation Trust.

The HSJ reported that a private company – One Primary Care, had been made the preferred bidder prompting one of the NHS providers to threaten a legal challenge.

Local GPs, who were part of the bid had raised their concerns about the plans to outsource services alongside objections from the local MPs, unions and local campaigners.

Halton CCG is understood to have abandoned the procurement after considering the responses and the potential delays and costs involved in defending the decision. The HSJ reported that One Primary Care are not considering their own legal action, but the CCG has not confirmed future arrangement beyond saying that they will continue with the current NHS providers in the short term.

Local MP Mike Amesbury, who joined a protest of UNISON members outside the one of the centres in Widnes told the Liverpool Echo “This is an important victory and just goes to show what can be achieved when we all work together to fight for our NHS.”

Mr Amesbury asked Health Secretary Matt Hancock if privatising the Runcorn UCC was part of his plan.

Mr Hancock’s enigmatic reply was: “The most important principle at stake is how to deliver the best possible services for our constituents”. 
Shropshire trust boss dumped overboard

On Monday, 3 June Simon Wright, the Chief Executive of Shrewsbury & Telford Hospital Trust (SaTH) announced he was stepping down. According to the trust he was to “take up a role working with sustainability and transformation partnerships,” which was apparently being seconded to Nottingham STP although this was quickly retracted.

It was obviously an unanticipated decision. After an unannounced visit the previous Friday by Prof Ted Baker, the CQC Chief Inspector of Hospitals, Wright reportedly told a meeting of his consultants that all was well, and he was in for the long haul.

Campaigners believe he has been pushed out. This might have been because the long drawn out acute hospital reorganisation, Future Fit, is not going well. Usually, the Secretary of State’s Independent Reconfiguration Panel (IRP) have required evidence of failure.

They are unimpressed by the clinical model put forward by SaTH that requires the closure of one of the two district hospitals.

They are visiting Shrewsbury to investigate and have scheduled a 2-hour meeting with Shropshire Defend Our NHS to give their evidence.

The reason might also be that SaTH was given an inadequate rating by the CQC last year. In particular, the organisation’s leadership was picked out as inadequate, and the trust failed on four out of five criteria. Since then, the trust has been placed in special measures, and there have been a further three enforcement notices issued against SaTH.

Wright was a devotee of the CQC and was sure they could not risk putting these cuts out to consultation.

However, with the Shropshire health economy required to make £1.5 million cuts this year, the trust was probably hoping they could hold back the tide, without an increase in finance. The latest letter to the Campaign from Simon Wright (who is Jeremy Hunt’s campaign manager), shows the Campaign’s political pressure is also beginning to take effect.

For the first time, the trust has admitted Shropshire has run up costs more money: “I shall continue to press for fairer funding for health.”

And the good news for Nottingham is that Simon Wright (whose record in the Nottingham BCC is not great) has been replaced by Social Care correspondent Michael Buchanan to comment “I doubt there will be many accounts of concern’ including baby and maternal deaths.

That is over double the number of cases investigated by the Independent Reconfiguration Panel (IRP) of Shrewsbury’s acute hospitals cases of concern” including baby and maternal deaths.

The IRP are unconvinced by the clinical model put forward by SaTH and have scheduled a 2-hour meeting with Shrewsbury Shropshire NHS Defend Our NHS.

The Campaign is not cost effective to monitor eligibility for NHS Care; ii) this meeting calls for the policy of charging migrants for NHS care to be abandoned and for the NHS to be free for all at the point of delivery; iii) this meeting believes that the overseas visitors charging regulations of 2011 threaten the founding principles of the NHS and that the regulations should be scrapped.

BMA votes to oppose racist NHS charges

The BMA has voted to oppose racist NHS charges.

BMA members have been asked to sign a petition in support of a motion to oppose racism in the NHS. The petition states that the BMA opposes all forms of discrimination and prejudice, and that it is committed to tackling racism within the NHS.

The motion was tabled by Dr Samira Mubashar, a BMA member from Manchester, at the BMA’s annual conference in September 2016. It was approved by a large majority of the delegates present.

The BMA stated that it would be working with other organisations to ensure that the motion is implemented effectively.

The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.

The BMA has been vocal in its opposition to racism within the NHS, and has called for action to address the issue. The BMA has also called for an end to the use of racist language and imagery in health care settings.
Implementation Framework published for Long Term Plan

Stand by for new round of secret plans

John Lister

The remaining list of “priorities” that have been downgraded includes prevention; maternity and neonatal services; children and young people; learning disabilities and autism; cardiovascular disease; stroke care; diabetes and respiratory disease.

Clearly some of these are potentially complex policy problems, and will inevitably also feature in any discussion of restricting demand, urgent and emergency care, primary and community care, cutting out 30 million outpatient appointments and increasing elective operations.

The requirement to expand elective services is also compounded by attempts by CCGs and trusts, and by NHS England’s own insistence that commissioners adhere to the controversial “Menu of Evidence Based Interventions” (EBI) which last year singled out 17 treatments for exclusion from routine referral.

Exclusions

This has in many areas been exceeded by much longer lists of exclusions drawn up by CCGs – as Health Campaigns Together warned a year ago. The Framework expects the EBI menu alone would result in a reduction of 128,000 elective operations a year (p30), but planned to expand it.

So the postcode lottery is not only alive and well, it is growing in scope. NHS England has taken no steps to ensure that CCGs with excessively long and unjustified lists, such as those that have not signed up to the same list of 71 treatments, including cataract and hip and knee replacements, which they say are of “low clinical value,” and as a result the operations remain no more than wishful thinking.

Workforce

Despite having only the sketchiest of “interim workforce plans” so far in place, local health chiefs are told that their plans “should be based on realistic workforce assumptions” (“which must be delivered within the local financial allocation,” p31) and “deliver all the commitments made within the Long Term Plan.”

To make the local task even more impossible the financial pressures on trusts and CCGs are being increased rather than relaxed: “Local plans will need to include the following priority for cataract operations, hip and knee replacements and other proven effective treatments, as a process to think again.

There is once again a gulf between words and deeds on the ground.

In words the Framework commits to ensuring that “System plans should demonstrate the key areas of inequality they will tackle and how additional funding is targeted” (p50). In deeds, when Warrington & Halton hospital trust offered to allow patients who could afford to reach a high threshhold of need. “Choice”

So patients in the area who are in pain but do not meet this threshold have a “choice” of going private … or waiting. However even as it was published it turns out that “asylum seeker” Cambridge & Peterborough CCG was discussing desperate cuts to reduce spending, including their emergency rapid response team for older people and patients with long-term conditions – which the CCG admits has “provided excellent patient facing care for patients”.

There is no explanation of what the Framework means by “digital and online services” as options for quick elective surgical care.

Private sector are winners from ‘postcode lottery’

John Lister

Warrington and Halton Hospitals Foundation Trust has been forced by public outcry to suspend its ‘controversial’ 2016 EBI menu which excluded £75m of NHS patients who are in pain but do not meet a high threshhold of need. “Choice”

They cite knee replacement prices varying from £9,559 to £15,202, while cataract surgery prices range from £1,650 per eye to £3,535. The varying prices have one thing in common: they are all out of reach of the poorest.

The public sector is not the only one to suffer. “It pays to ‘shop around’. There are wide price variations for ‘fixed price surgery’ across the UK,” according to a new “Self Pay UK market report” at the end of last year. Around 800,000 healthcare treatments every year are privately funded: in 2017 one in four of all elective treatments were self-pay.

Whether its private hospital chains or Foundation Trusts with their hand out demanding cash for routine treatments and a high threshhold of need, such as IVF and donor sperm, patients are faced with an erosion of the NHS, and a drift back towards the grim days before 1948 when millions could not afford to seek medical care and were forced to suffer in silence.

The starting point for this is the long and growing list of exclusions. Last week it took an intervention from the Department of Health and Social Care to prevent a decision by Cambridge and Peterborough CCG to impose an indefinite ban on NHS funding for IVF treatment, to save money towards its £175m deficit.

Ministers must now step in to force CCGs elsewhere to abandon the race to the bottom put in the way of access to routine care under spurious claims that well-proven operations are of “low” or “limited” clinical value.
Our health in Boris Johnson’s hands: what would we do?

Boris Johnson has questioned the use of what he calls “sin based taxes” to combat the national obesity crisis just days before ministers plan to extend the idea.

So how will the frontrunner to become the next PM look after the nation’s health? PAUL EVANS investigates this less explored aspect of his politics.

Johnson says he wants to promote walking and other exercise instead of imposing sugar taxes on producers to reduce the sugar, salt and fat in their food and drinks. He is of course showing off his low tax credentials to the Tory faithful and stumping a populist beat against the interfering nanny state – mission accomplished, but what about the obesity crisis?

Britons are the fattest in Western Europe. Two thirds of us are overweight, nearly a third are obese, and this is the second biggest cause of cancer after smoking – according to Cancer Research UK.

Young adults who become obese in their 20s can expect to lose 10 years off their life according to research.

It’s expensive too, with the NHS spending 10% of its budget on diabetes-related diseases alone, the vast majority of that on the preventable type 2.

Ministers plan to extend the sugar tax to include milky drinks, after the levy successfully encouraged producers to reduce sugar content. Downing Street have been won over to the strategy, and a Green paper is imminent.

Meanwhile Johnson is putting in the opposite direction, asking for a review of the evidence, much of which is to the strategy and a Green paper is imminent.

More money for the NHS?

We learned recently that Johnson will not be prosecuted over his Brexite revolution claim that the UK sends £350 million to the EU every week, but he is still under investigation. The review of the evidence calls for a review of the evidence, much of which is to the strategy and a Green paper is imminent.

The controversy over the bogus pledge has stuck. Fellow Brexiteer Jacob Rees Mogg believes, “the promise must be delivered” and Johnson has been going out of his way to pledge for more funds for the NHS ever since.

As a secretary, he marched into a cabinet meeting to demand £1bn for the NHS. A stunt spurred in the media, which did much to expose his leadership ambitions.

Last month, writing for the Telegraph he hammered out another call for funding.

“We need to keep putting more money into the NHS. Of course we can make the system more productive, and of course it will become more efficient – but we must put the money in. The only argument is over how to find that cash.”

Yes – How would he find the cash? Might he ask some patients to pay for care, or restrict treatment with a batch of new charges? Ever the hapless apple when it comes to detail, Johnson has not answered the key questions, including about how much he would spend.

Economists agree the NHS needs at least about 4.5% extra a year and billions and more in upfront funding to pay for extra staffing and hospital repairs that have built up over austerity.

The decision over extra funding was to take place this summer in the government spending review, but in a painful irony the Tory leadership campaign has pushed this back, delaying any prospect of extra money for the NHS.

The Health Foundation has calculated that an additional £3.2bn a year is required to reverse the impact of government cuts on public health which reduced obesity programmes, drug and alcohol services and sexual health services over the last five years.

But what does he really think?

During the Brexit campaign traditional royalties were cast aside. On the BBC Marr programme the ex PM John Major revealed Johnson’s view on the NHS alongside other prominent Tory Brexiteers.

Gove had wanted to privatisethe NHS, Johnson wished to charge people for health services and Duncan Smith favoured a move to a social insurance system.

“The NHS is about as safe with them as a pet hamster would be with a hungry python,” Major said – ouch.

In 2003 Johnson wrote “If NHS services continue to be free in this way, they will continue to be abused like any free service,” adding, “if people have to pay for them, they will value them more.”

That’s certainly a sentiment that his leadership campaign team would bind and gag him to prevent him from uttering today.

Open to persuasion?

Johnson has dismissed accusations that he has been taking advice from the far right commentator Steve Bannous, calling it a “shady delusion whose spores continue to breed in the Twittersphere”.

However, a video obtained by the Observer reveals Bannous talking about helping to craft Johnson’s first speech after he resigned as foreign secretary.

When it suits, Johnson has also deployed his pen in defence of beds cuts and opposed the closing of community hospitals. But warm words, flag waving and an unhealthy appetite for popular solutions will make NHS leaders nervous.

The last thing they need is more muddled thinking and knee jerk policy.

Others already smell the opportunity to set a new policy agenda. The right-wing Institute for Economic Affairs has wasted no time in sticking the boot into Johnson’s plan for extra spending, demanding that he end the NHS ‘socialist experiment’ and heavily reform the service. With his close links to Tory ministers public statements by the IEA will no doubt be closely followed by private lobbying.

The truth is we can’t know how Boris Johnson will look after the nation’s health, probably because he doesn’t yet know himself.

As ever though the best defence will be a watchful eye, and the best policy will be one that works. In a world where it is about as safe with Boris Johnson as a pet hamster would be with a hungry python, there is hope for reform.
Sylvia Davidson

As the summer hots up, hospital trusts are busy making plans for how they are going to cope with the coming winter.

A regular feature of these plans is buying bed capacity in the private sector - once purchased on an ad-hoc basis, it now seems that some private sector involvement is becoming more permanent.

This week, it was reported on Royal Surrey County Hospital Foundation Trust’s winter plans; according to board papers seen by HSJ, the trust plans to switch from temporarily booking of private beds in busy periods to block-booking private beds in advance to ensure that all surgical lists can be outsourced at peak times.

The likely candidate lists are urology, orthopaedics and benign gynaecology.

Hospital trusts have also been told by NHS England to reduce elective work over the busy periods. However, Royal Surrey found that cancellations due to bed shortages increased and its A&E performance suffered.

So this coming winter the trust is considering ways to reduce its elective work earlier in the year and plans to outsource entire surgical lists to private companies.

National bed shortage

All trusts are experiencing a shortage of beds. In 2010/11 the number of general and acute beds in the English NHS was 110,000 and this had fallen to 103,000 in March 2019, and in late 2018 was at 100,500.

A fall of around 7,000 beds across a period of rising activity has resulted in increased waiting times, including the number of people facing a wait of over a year.

NHS trusts are under immense pressure to reduce waiting lists. The target is to treat 92% of patients within 18 months maximum waiting time.

In response hospitals have been forced to seek capacity in the private sector. Figures for hip and knee replacements show how the role of the private sector has grown - in 2012/13 20.4% of hip and 13.7% of knee replacements were carried out in the private sector, but this has risen to 29.4% and 19.7% by 2016/17.

In 2017/18 concerns over pressures on A&E prompted NHS England to advise hospitals to put in place a blanket ban on elective surgery to help cope with emergencies.

Urged to ‘go private’

As result waiting lists rose to the highest level in a decade at 4.35 million in mid-2018 and local NHS leaders received more guidance, urging them to ‘go private’ providers to reduce treatment delays.

More targets on waiting arrived in 2018 along with the revelation that a list of NHS trusts under extreme pressure to reduce their waiting lists had been drawn up by regulators and circulated to private providers including, Spire Healthcare, Care UK and Nuffield Health. A policy of using private providers to reduce waiting lists is firmly back in favour.

After several years of high pressures, it is now clear that trusts are struggling to cope with the level of activity all year round. What were ad hoc arrangements with private providers primarily in the winter months, are now expanding to cover all year round and are becoming more permanent fixtures.

University Hospitals Plymouth Trust’s 18 month partnership with Care UK will move 75% of its elective orthopaedic work to Care UK’s neighbouring facility. The unit will be staffed by NHS staff but managed jointly by Care UK.

By adding bed capacity, the trust hoped to improve its waiting times for elective orthopaedic surgery.

And in June Northumbria Healthcare Foundation Trust announced the signing of a contract with the private Rutherford Cancer Centre’s facility in the North East for chemotherapy patients.

The trust noted that the partnership, which will initially treat around 150-150 breast cancer patients per year, is designed to help the trust ensure treatments for cancer patients are not delayed due to lack of capacity in the trust.

Despite the arrangements with private companies, at the end of March 2019, the waiting list was almost 6% higher than in March 2018. The only bright spot was a reduction in the number of patients waiting over a year for treatment, down 5% compared to March 2018.

Recognition from the top

Finally, in June 2019, Simon Stevens acknowledged at the NHS Confederation’s conference in Manchester that

NHS Providers remind us of the winter’s tale

John Lister

A few days after midsummer NHS Providers is already keen to focus on the problems set to recur with winter this year.

It is urging health leaders not to draw false comfort from the noticeable absence of stories about ‘winter pressures’ in the media earlier this year.

A new briefing, The Real Story of Winter, argues that while preoccupation with Brexit has diverted attention away from vital challenges, performance against key standards continues to show the NHS remains in “perpetual winter”.

Rising demand

It sets out the growing pressures facing our health and care services, and notes that:

“An analysis of NHS England and NHS Improvement shows a widening gap between the demand for care and the capacity of the service – in terms of staff, beds and – to meet it.”

The key issue is that the NHS is now treating more patients than ever, as the population increases and the proportion of older people continues to grow.

Last winter:

- There were 8.1 million accident and emergency attendances, an increase of 5% from the previous winter and a 16% increase since 2014/15.
- On average, 66,300 people were being admitted to England each day over winter.

An earlier BMA report, NHS Pressures – Winter 2018/19: A hidden crisis, added further dramatic figures to illustrate the pressures on front line services and staff.

In particular during the 2018/19 winter:

- NHS hospitals admitted 1.62 million emergency cases, a rise of 6% from the previous winter and up by one in six (16%) since 2014/15.
- 4.3 million people are now waiting for elective treatment.
- 3.9 million attending major A&Es.

This represents a 6% increase on last year.

- There were 214,000 trolley waits over winter, recorded, and 1,465 of over 12 hours.
- 96% of trusts exceeded recommended occupancy levels.

Excluding 21st to 29th December, bed occupancy did not drop below 92% all winter. Croydon Health Services reported the highest average bed occupancy over the winter, with 98.6% of beds occupied, having been at 100% occupancy on most days over the winter.

The total number of general and acute beds peaked at 98,826 this winter, down on 99,298 last year. NHS figures show that in the winter of 2010/11 when the austerity regime first kicked in there were 105,000.

NHS Providers argue that the low profile of the issues in the media ignores a further deterioration.

“Despite much milder weather, with a less severe strain of flu, last winter saw the worst A&E performance against the four hour target since records began, and one of the most challenging winter performances recorded against key cancer standards.

“Moreover, the elective care waiting list is at record levels, with more people waiting longer than the recommended 18 weeks for routine operations.”

New performance measure

Some of the comparative A&E figures will be impossible to compile this coming winter, since 14 NHS trusts are now testing out a new formula for measuring performance as ministers and NHS England try to escape the embarrassment of continued failure to deliver the promised 4-hour maximum waiting time.

But NHS Providers’ director of policy and strategy, Miriam Deakin said: “We must ensure change is not recommended simply because the service is struggling to deliver existing targets.”

Bed shortage forces NHS to look to private sector

The lowdown
Digital technology and nursing care: is it an evidence-free zone?

With a current health secretory so openly enthusiastic to promote apps and digital “solutions” in the NHS it’s useful to check on what level of evidence there is available on how useful the new technology and software really is.

It seems there is relatively little appetite to find out perhaps because those marketing the new digital devices and technology are less than keen to have it thoroughly tested. Only recently Slavinsky [1] referred to research on its website to a high-profile test of its controversial chatbot which had appeared to show it competing successfully against real doctors, after the validity of the test was disputed by some NHS management.

A large number of studies have a low level of evidence. Efficiency studies are very rare in general. This points to the low consideration of the relationship between benefits and costs of a technology, so far.

The German team also note that the way their study had been organised made it less likely they would find any research papers critical of the new technology, almost all of which are to be found outside the mainstream of academic journals: “We considered published scientific studies only, and no grey literature (research that is either unpublished or has been published in non-commercial form). This review therefore tends to contain fewer publications with negative or neutral findings. Consequently, it can be assumed that there may be a bias towards promising technologies.”

With a current health secretory so openly enthusiastic to promote apps and digital “solutions” in the NHS it’s useful to check on what level of evidence there is available on how useful the new technology and software really is.

Little evidence on cost effectiveness

A large number of studies focused at all on costs of technology, and very few included full economic evaluations: most studies categorized as “efficiency-studies” offered only simple cost analyses. Indeed other than 60% of studies analysed aspects of the effectiveness of the technology, less than 6% analysed efficiency or included a cost analysis. Just 13 studies out of the 715 analysed cost-effectiveness. Only 4 offered a cost-benefit or cost-effectiveness ratio.

There was also little focus in the research on digital support for informal carers or support for informal care givers. The NHS has also attempted to promote apps and digital “solutions” in the NHS it’s useful to check on what level of actual evidence is available on how useful the new technology and software really is.

Fines are a blunt instrument for cutting hospital readmissions

A new study in the US journal Health Affairs looks at the impact in US hospitals of financial penalties imposed under Obamacare to force hospitals to reduce excess levels of readmission for patients who had certain medical and cost-utilty treatment. The NHS has also attempted to use financial penalties as a way to deter readmissions.

The authors begin by stressing that “Hospital readmissions are common, costly, and as they are often preventable – a marker for poor hospital quality.” The penalties announced in 2010 and imposed for certain medical and surgical treatments. The NHS has also attempted to use financial penalties as a way to deter readmissions.

In fact the authors suggest “Our findings also suggest that reducing readmission of patients facing a ‘floor,’ and that a certain level of readmission may be necessary and a sign of appropriate care for surgical patients.” The authors go further, noting evidence that penalties for readmissions only increase mortality for certain conditions, as some patients who should have been readmitted were instead discharged from the emergency department and died at home.

Indeed many business cases are little more than cynical PR spin to sell a proposed change rather than a serious and critical exploration of the facts. The researchers’ “top-down” approach is made worse by the fact that rather than assessing major business cases in the public domain, they chose instead to “maintain ongoing dialogue with identified ‘gatekeepers’ within the CCG to gain access to business cases.”

While the critique offered by this paper is definitely better than no critique at all, the authors have bought so heavily into the relationship with the CCG that they fail to see any need to acknowledge or relate to the type of criticisms raised of business cases over the years by critics including local councils, trade unions, health professionals, community campaigners and politicians.

These critiques tend to focus on the merits of the changes being forced on the “evidence” produced, the practicalities in terms of funding and staffing, the viability of the plans, and the needs of the patients affected.

The authors, for example, present the “a poor business case may be occasionally made by serious case with multiple decision-makers taking the risk.” They correctly make the point of big does not mean better: “Longer business cases were not necessarily a better option, providing full coverage of the quality indicators, indicating that length alone does not necessarily guarantee quality.”

However they go on without any sense of irony to discuss the application of the ‘SMART’ approach (specific, measurable, achievable, realistic, time-bound) of having found that fewer than half of the NHS business cases analysed (77%) even included explicitly labelled aims or objectives. They also note that “only one business case explicitly linked its proposal to a set of local targets.”

To progress beyond this limited exercise the authors would have needed to acknowledge or relate to the type of criticisms raised of business cases over the years by critics including local councils, trade unions, health professionals, community campaigners and politicians.

Nor do their examples include any of the high profile business cases for major hospital reconfiguration. The authors appear unaware of any stakeholders outside of the narrow management bodies who are drawing up and appraising the business case, so any notion of public accountability is entirely lacking.

The authors do not ask whether the business case is drafted by the NHS managers responsible for delivering services, or contracted out to high cost, management consultants.

Moreover, they do not point to the researchers’ limited and rather naïve approach, none of the questions they ask of business cases includes any critical appraisal of the honestly and integrity of the documents, and no check on the assumptions made or the quality of the so-called ‘evidence’ on which the business cases are based. There is no serious discussion of equality issues.

The study limits itself to cases for relatively small scale projects, and appears to ignore any public right to know or be consulted. The authors seem unaware of the way in which for decades complex, tendentious “business cases” have been used by some NHS managers in the way a drunk uses a lamp-post: more for support than illumination.

The survey, which covered a total of almost 2.5 million patients, found that the penalties had a “great impact” on readmission reduction for patients who had certain medical and surgical treatments. The NHS has also attempted to use financial penalties as a way to deter readmissions.

While the limited critique offered by this paper is definitely better than no critique at all, the authors have bought so heavily into the relationship with the CCG that they fail to see any need to acknowledge or relate to the type of criticisms raised of business cases over the years by critics including local councils, trade unions, health professionals, community campaigners and politicians.

The authors, from Bristol and Birmingham universities, do however recognise that: “a poor business case may be occasionally made by serious case with multiple decision-makers taking the risk.” They correctly make the point of big does not mean better: “Longer business cases were not necessarily a better option, providing full coverage of the quality indicators, indicating that length alone does not necessarily guarantee quality.”

There’s a real world out there: it would be good to see academics engaging with it a little more.

The authors do not ask whether the business case is drafted by the NHS managers responsible for delivering services, or contracted out to high cost, management consultants.

Moreover, they do not point to the researchers’ limited and rather naïve approach, none of the questions they ask of business cases includes any critical appraisal of the honestly and integrity of the documents, and no check on the assumptions made or the quality of the so-called ‘evidence’ on which the business cases are based. There is no serious discussion of equality issues.

The study limits itself to cases for relatively small scale projects, and appears to ignore any public right to know or be consulted. The authors seem unaware of the way in which for decades complex, tendentious “business cases” have been used by some NHS managers in the way a drunk uses a lamp-post: more for support than illumination.

“A recent survey confirmed the profound influence of the HRRP’s penalties: Following the implementation of the policy, 66 percent of hospital leaders reported that the program has had a strong reduction in readmission efforts, and nearly half reported that readmissions were their top priority.”

The survey, which covered a total of almost 2.5 million patients found that the penalties came at a time when readmission rates were already falling, and accelerated them not only for the medical specialties, but also had an impact on readmission of patients after knee and hip replacements.

Fines are a blunt instrument for cutting hospital readmissions

So when the additional penalties to reduce readmission of surgical patients came in it had little or no effect.

In fact the authors suggest “Our findings also suggest that reducing readmission of patients facing a ‘floor,’ and that a certain level of readmission may be necessary and a sign of appropriate care for surgical patients.”

The authors go further, noting evidence that penalties for readmissions only increase mortality for certain conditions, as some patients who should have been readmitted were instead discharged from the emergency department and died at home.

There are also equality issues arising from the penalties:

In fact the penalties may have played a relatively minor role in the reduction in readmissions, as the main drivers were around the quality indicators, indicating that length alone does not necessarily guarantee quality.”

There’s a real world out there: it would be good to see academics engaging with it a little more.

Indeed many business cases are little more than cynical PR spin to sell a proposed change rather than a serious and critical exploration of the facts. The researchers’ “top-down” approach is made worse by the fact that rather than assessing major business cases in the public domain, they chose instead to “maintain ongoing dialogue with identified ‘gatekeepers’ within the CCG to gain access to business cases.”

While the critique offered by this paper is definitely better than no critique at all, the authors have bought so heavily into the relationship with the CCG that they fail to see any need to acknowledge or relate to the type of criticisms raised of business cases over the years by critics including local councils, trade unions, health professionals, community campaigners and politicians.

These critiques tend to focus on the merits of the changes being forced on the “evidence” produced, the practicalities in terms of funding and staffing, the viability of the plans, and the needs of the patients affected.

The authors, from Bristol and Birmingham universities, do however recognise that: “a poor business case may be occasionally made by serious case with multiple decision-makers taking the risk.” They correctly make the point of big does not mean better: “Longer business cases were not necessarily a better option, providing full coverage of the quality indicators, indicating that length alone does not necessarily guarantee quality.”

They correctly make the point of big does not mean better: “Longer business cases were not necessarily a better option, providing full coverage of the quality indicators, indicating that length alone does not necessarily guarantee quality.”

There’s a real world out there: it would be good to see academics engaging with it a little more.
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. Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – something 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.

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 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

In our first year we will:

- establish a regular 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