THE lowdown

OUR FIRST YEAR

Informing, alerting and empowering NHS staff and campaigners

A unique resource for unions, campaigners and researchers

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The first pilot issues of the Lowdown were published in January 2019, with the first formal issue at the end of April.

This collection brings together the first 22 issues as a single searchable database of almost 200 pages, with all of the links live.

Readers have told us how they value the ***Lowdown*** as a unique source of coverage on many trade union disputes, as a source of new stories not otherwise available, as well as a distinctive take on stories that can otherwise only be found in various specialist and paywalled publications.

We have been providing this information free to all -- but it is far from free to produce. We know many readers are willing to make a contribution, but have not yet done so.

If you want up to date information, backed up by hard evidence, that helps campaign in defence of the NHS, please help us fund it.

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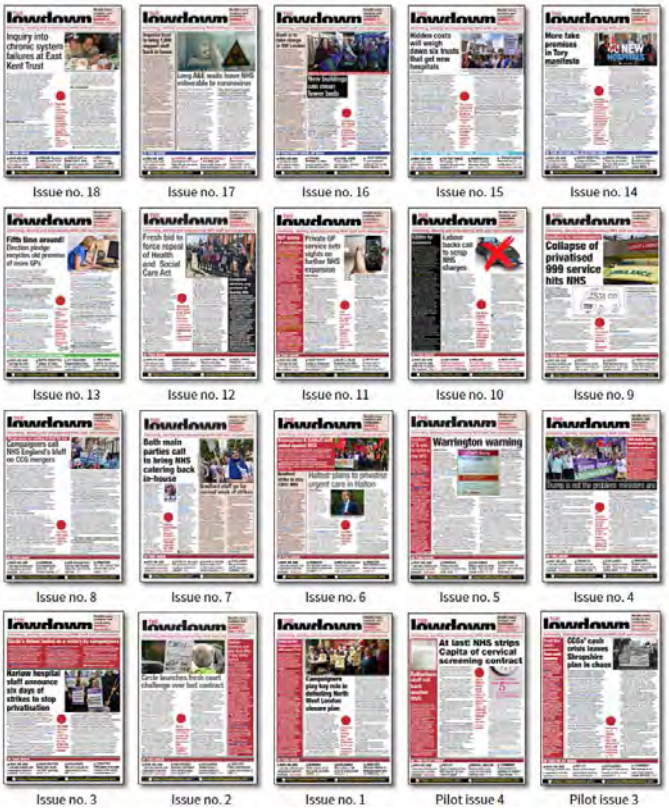
We suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can give us more, please do.



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'Now needed more than ever, The Lowdown provides a well researched antidote to politicians' and managers' lies about the disassembly of the NHS' –
Ted Schrecker, Professor of Global Health Policy, Newcastle University.

"It is a classy fount of investigative journalism,"
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"The Lowdown is a new left-wing magazine-style newspaper looking in depth at health and social care news stories. It is from distinguished NHS journo John Lister & Co.
"It is well worth a cuppa-builder's and a Hobnob read.
"It'll develop into something between the Guardian, Private Eye and the FT."
Roy Lilley, health policy analyst, and commentator on NHS and social issues.

'Great journalism giving campaigners the evidence we rely on to defend the NHS - a really valuable asset."
Tony O'Sullivan, Co-chair Keep Our NHS Public

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Please send us a donation … but also please propose to your regional and national committees that they invite one of our editors to speak about the project and appeal for wider support.

For this, or if you have any other queries or suggestions for stories we should be covering, contact us at ***contactus@lowdownnhs.info***

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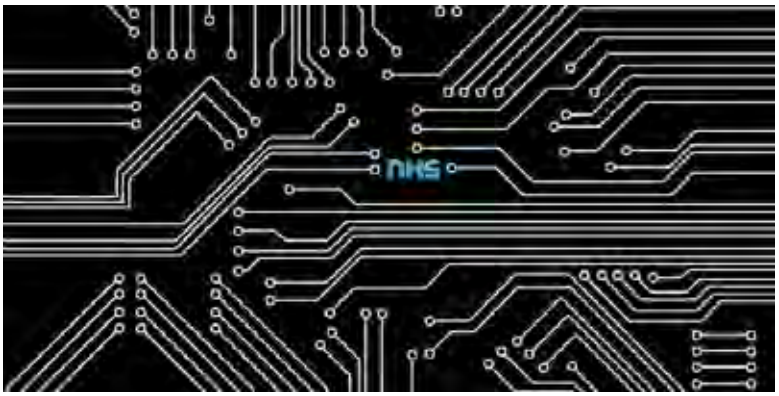
THE lowdown

Health news, analysis and campaigns.
PILOT ISSUE #1
February 11 2019

Informing, alerting and empowering NHS staff and campaigners

New rules to protect GPs from digital



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

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

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

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

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

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

Younger, fitter patients

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

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

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

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

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

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

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

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

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

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

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

Do ministers really want to change the regulations?

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

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

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

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

IN THIS PILOT ISSUE

Genome sequencing threatens core principle of the NHS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NHS England to ban GPs from advertising private services

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

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

The new GP contract states that:

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

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

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

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

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

This ban will not prevent GPs working privately

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The letter goes on:

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

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

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

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

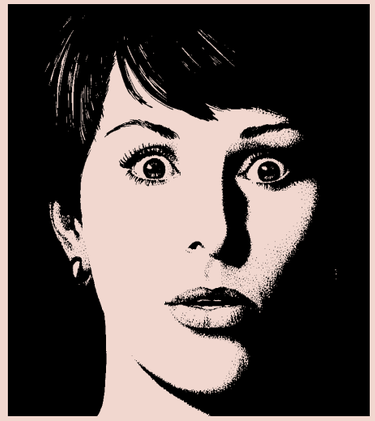
John Lister

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

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

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

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



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

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

Packages

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

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

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

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

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

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

Below the radar

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

John Lister

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

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

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

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

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

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

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

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

Local plans

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

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

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

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

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

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

A&E downgrades

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

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

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

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

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

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

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

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

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

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

Doctors versus doctors

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

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

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

"Integration"

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

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

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

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

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

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

Staffordshire war-chest for legal challenge

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

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

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

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

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

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

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

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

Ouch – time to end the pain and injustice of NHS

Paul Evans - Comment

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

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

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

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

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

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

Desperate measures

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

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

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

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

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

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

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

The root cause?

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

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

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

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

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

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

Brexit factor

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

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

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

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

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

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

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

Mr Hancock's Solution?

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

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

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

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

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

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

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

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

The health secretary was warm in his praise:

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

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

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

Charges

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

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

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

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

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

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

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

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

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

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

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

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

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

Sleep at work

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

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

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

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

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

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

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

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

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

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

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

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

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

Mysterious notes and a US company create confusion in Weston plan

John Lister

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

The plans centre on three basic proposals:

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

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

Private hospitals

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

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

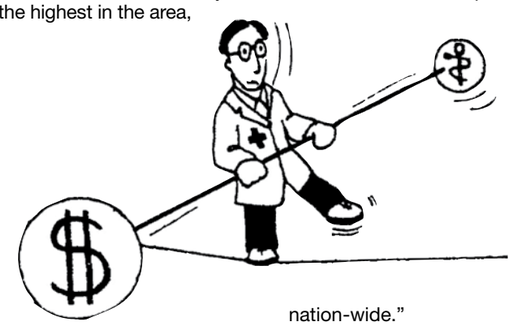
More figures show that while 71% of Weston hospital non-elective inpatients stay longer than 8 days, this is only slightly higher than the 70% figure for Taunton, which has a much higher proportion of patients staying 8-30 days.

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

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

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

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



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

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

Footnote

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

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

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

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

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

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

Florida based

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

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

Contrast

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

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

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

How would such a huge upgrade be paid for?

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

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

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

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

Shropshire appendices removed

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

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

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

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

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

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

Cock-eyed Optimityism

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

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

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

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

Hypothetical

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

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

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

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

Not published

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

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

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

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

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

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

Aspirational

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

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

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

Just when you think privatisation is going away

Richard Bourne

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

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

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

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

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

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

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

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

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

NHS campaign groups in and around Bristol and the South West need to get work out how best to fight this short-sighted

What the (research) papers say

Clerical support

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

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

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

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

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

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

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

The Plan includes a list of over 60 uncosted commitments

Integration no panacea

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

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

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

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

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

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

Long Term Plan

Living in DENIAL

John Lister

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

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

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

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

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

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

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

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

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

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

The Plan includes a list of over 60 uncosted commitments

Long term plan pushes privatisation

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

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

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

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

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

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

THE lowdown

Health news, analysis and campaigns.
PILOT ISSUE #2
February 22 2019

Informing, alerting and empowering NHS staff and campaigners

NHS kept on a short leash

The ***Health Service Journal*** has picked up the tough new Department of Health and Social Care regime aimed at gagging "arm's length" NHS bodies that reveal the scale of the problems posed by Brexit.

Headlined 'DHSC slaps down quangos over Brexit messages,' it quotes from a leaked email from DHSC director of communications Rachel Carr, angry at a story in the media about the NHS Blood and Transplant Authority cancelling blood donation sessions, arguing:

"This was not cleared either through the EU exit comms team, at DHSC or through the secretary of state."

So-called arm's length bodies include the Care Quality Commission, NHS England, NHS Improvement, Public Health England and the National Institute for Health and Care Excellence

This latest shot across the bows shows that they are not really at arm's length at all, but on a short leash, and under the thumb of ministers and Department bureaucrats.

"No privatisation" promise under strain from multi-billion NHS outsourcing plans

Paul Evans

Private companies are in a 3-way fight for the biggest ever NHS pathology contract, just a month after the health secretary committed to prevent NHS privatisation.

Labour has identified a further £128million NHS tenders in the pipeline and is calling for Matt Hancock to step in "to keep them in public hands"

It emerged this week that private companies are involved in each of the three bids to supply pathology services to a group of hospitals in London and across the South East, making it very likely that the new service will be outsourced. The £3bn contract is the largest of its kind and could run for 20 years.

Also this week, NHS England granted private provider Babylon Health the right to extend their digital GP at Hand service into Birmingham, despite objections from GP leaders and before a review can present its conclusions.

In a further development research for the Labour party has identified 26 NHS tenders that have been advertised and it has accused the Health Secretary of going back on his recent "concrete" commitment, before a committee of MPs, that there would be "no privatisation on my watch".

Mr Hancock's statement had seemed to be part of a choreographed move away from market-based solutions within the NHS. It followed a call from NHS England, for ministers to abandon the controversial competition rules, a request that was written into the Long Term Plan and signed off by Downing Street.

"This Health Secretary's privatisation credentials become clearer by the day," says Labour's Jonathan Ashworth

However, despite the apparent accord between the NHS and ministers on the competition regulations, they remain in place. NHS commissioners are obliged by law to advertise many larger NHS contracts, giving firms like Virgin Care the chance to bid.

Figures from the NHS Support Federation show that since these rules came into place over £25bn worth of NHS contracts have been advertised and nearly 40% of them have been won by the private sector.

In comments to the Press Association Labour's health spokesperson Jonathon Ashworth said

"This Health Secretary's privatisation credentials become clearer by the day, whether it's promoting GP at Hand to endorsing private dentistry to now allowing millions of pounds worth of health services contracts to be privatised,"

A Department of Health and Social Care spokesperson responded:

"We're committed to providing world-class NHS services that are always free at the point of use and are investing £20.5 billion a year extra by 2023/24 to guarantee the future of our health service through the NHS Long Term Plan.

"These decisions are clinically-led by NHS experts and based on what's best for patients."

IN THIS PILOT ISSUE

Biggest ever pathology contract to go to private bid

A contract for to set up the largest ever pathology network was launched In September 2018 and this week news about the shortlist of bidders makes it very likely that it will go to a private provider.

Eight hospital trusts advertised a pathology contract worth £3bn over 20 years, which aims to link services as part of new hub and spoke network. The *Health Service Journal* published details of the three shortlisted bidders, but their names have not been confirmed by local commissioners. They are:

- Health Services Laboratories (a joint venture between the Royal Free London Foundation Trust, University College London Hospitals FT, and The Doctors Laboratory)
- Synlab Group
- Incumbent provider Viapath (a joint venture between Guy's and St Thomas' FT, King's College Hospital FT and Serco)

The network will serve at least 8 trusts across London and the South East. The scale of the procurement was set after a review from Lord Carter identified potential savings of £200m from setting up a hub and spoke networks, linking services together.

The hub hospitals will provide more complex services whilst the smaller hospitals focus on simpler pathology work for their own hospital.

The existing contract is currently held by Viapath, a company owned by Serco and the two trusts, who have already transferred NHS staff to work for them. If they won, the new contract would expand this arrangement.

The contract will be awarded in September, and the new service is expected to be in place by September 2020

The contract will be awarded in September 2019, and the new service is expected to be in place by September 2020.

Lewisham and Greenwich Trust has refused to be part of the procurement because it is considering a solution that keeps its pathology provision within the NHS.

Commenting on the procurement Sarah Cook health lead for Unite London and Eastern region, who have members in many of the trusts involved said

"We have concerns about the protection of jobs and whether this is extending privatisation by the back door. We would support bringing these services back-in house."

The eight trusts involved are:

- Guy's and St Thomas' FT
- King's College Hospital FT
- East Sussex Healthcare Trust
- Epsom and St Helier University Hospitals Trust
- Oxleas FT
- South West London and St George's Mental Health Trust
- South London and Maudsley FT
- Royal Brompton and Harefield FT

How long will Interserve survive?

Just over a year after the collapse of leading contactors Carillion with job losses and disruption, another multinational support services and construction company, Interserve, is struggling for survival.

Interserve is UK based, and had revenue of £3.25 billion in 2017 and a workforce of more than 75,000 people worldwide. 70% of its turnover is from UK government projects and contracts, including support services in NHS hospitals and social care.

Interserve Healthcare provides staff for both NHS and nursing/care home facilities; it also provides complex care both in a home and community based setting.

It operates through a network of 26 branches and works with CCGs, Social Services, private and NHS hospitals, nursing homes and learning disability establishments as well as delivering care to private clients in their own homes.

However like Carillion, Interserve's dividends to shareholders grew faster than its actual profits and by 2017 it was reporting a loss of £254m, more than double the 2016 loss of £102m.

No lessons have been learned from Carillion collapse

To cover dividend payments and losses Interserve borrowed heavily, with long term debts of £807m in 2018: interest charges are ncreasing on these debts and the firm also owes its pension scheme £48m.

Despite ministerial assurances in January 2018 that Interserve was "not another Carillion" it's clear that no lessons have been learned from that collapse.

The company's survival after a bail-out deal earlier this month that involves cutting its debts from over £600m to £275m by issuing new shares.

The rescue deal hangs on the willingness of banks to prop it up, and hold on to shares that will generate little if any return.

Interserve retains a portfolio of low margin contracts and continuing losses. How long can that continue?

Profits Spiralling down

Despite moves by many Clinical Commissioning Groups to draw up ever longer lists of treatments that are not to be routinely funded by the NHS – effectively pushing more patients towards the choice of going private or going without– it seems the private hospitals are struggling.

Patients without insurance remain reluctant to self-pay for private treatment.

Spire Healthcare, Britain's second largest private hospital company with 39 hospitals and 11 clinics, is blaming reduced numbers of NHS-funded patients, and a likely increase in staffing and other costs after Brexit for a continued worsening of its finances and prospects.

Last September the firm noted the "unprecedented decline (both in scale and speed)" of NHS funded admissions: its adjusted pre-tax profits more than halved to £16.4m in the six months ended June 30.

Swiss Bank Credit Suisse has downgraded its rating for Spire, in the expectation the market for private healthcare will get worse again in 2019.

So at least there is some good news to relieve the general gloom.

Priory-owned hospital closes after critical watchdog report

A hospital for young people with learning disabilities owned by the private mental health company, The Priory Group, has been closed following a CQC report that put it into special measures.

The regulator's report was damning, with an overall 'inadequate' rating and a conclusion that the hospital was "not adequately equipped to care for young people with complex needs".

The Priory has now closed the hospital, based in High Wycombe, and moved the patients to other units. The hospital only opened in April 2018.

Pauline Carpenter, Head of Hospital Inspection (and lead for mental health) at the CQC, said:

"Our inspection has identified a number of serious problems concerning patient safety and the quality of care that needed immediate attention.

"It was a matter of some concern that, at a specialist unit, some of the staff could not demonstrate the knowledge or specialist skills needed to care for teenagers who had learning disabilities or autism.

Shocking

The inspection reported a number of shocking findings, including a young person with complex needs who managed to swallow objects such as screws, wire and a part of a radiator grill; medication errors; no access to psychological therapies for the patients; and the layout of the ward itself being unsuitable for young people with autism as it was disorientating and noisy.

This damning CQC report comes hard on the heels of The Priory pleading guilty to health and safety charges following the death of 14 year old Amy El-Keria in 2012.

The company is owned by the US company Acadia and had reported income of £796.6 million in 2017

The case, which was heard in Brighton Magistrates Court in January 2019, could result in a fine of more than £2 million for the company, according to a report in the HSJ.

In 2016, an inquest ruled that the death of a 14 year old Amy El-Keria in 2012 at Ticehurst House, a Priory hospital, was as a result of months of serious failings at the hospital, including staff failing to pass on the fact that she had spoken of wanting to end her life. The inquest also ruled that staff failed to dial 999 quickly enough and failed to call a doctor promptly.

Responding to the guilty plea, Amy's mother Tania El-Keria said:

"Amy's mental health care should never have been in the hands of a company whose priority was placing profit over her safety. For 14 years we kept her safe but within 3 months with the Priory she was dead."

The Priory Group, which operates as both The Priory and Partnerships in Care, is a leading provider of mental health services to the NHS.

The group's services include in-patient and out-patient services that cover a wide range of psychiatric conditions, including drug and alcohol rehabilitation, plus learning disabilities.

The company is owned by the US company Acadia and had reported income of £796.6 million in 2017.

The Priory has been the subject of several reports of failures in care in recent years, including other patient deaths.

Early in 2016, the family of 17-year-old Sara Green, who died in the Priory Royal in Cheadle in 2014, called for the company to have its NHS contract cancelled.

Then in March 2016, the Priory and Solent NHS Trust admitted liability for the death of 15-year-old George Werb, who had been a patient at the Priory Hospital Southampton.

No workforce plan = no plan at all

One of the striking omissions from NHS England's Long Term Plan published last month was of course the lack of any workforce strategy as the number of unfilled vacant posts has risen above 100,000, and many key services are finding it hard to recruit and retain the staff they need.

A major new report on staffing from the Health Foundation highlights some of the issues that NHS England and the government have to get to grips with if there is to be any serious effort to resolve a major and growing obstacle to maintaining viable services.

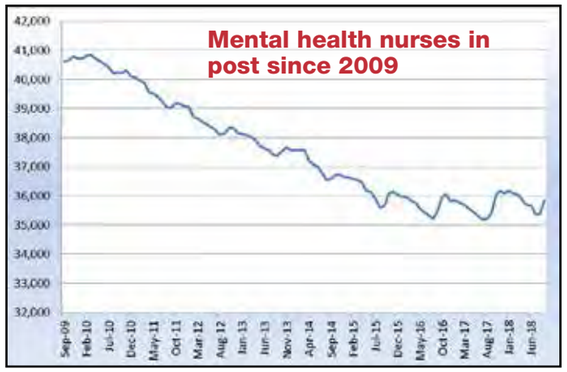
It notes a small scale (less than 2%) overall increase in staff numbers which is nowhere near enough to meet the needs for more nursing and professional staff.

There was less than a 1% increase in numbers of midwives and an even smaller (less than half a percent) increase in nurses and health visitors, although this masks an actual reduction in numbers of health visitors. Mental health nurse numbers have risen by less than 0.5% despite the government's 2017 promises to recruit an extra 21,000 mental health staff.

Numbers of GPs have also fallen, again despite promises in the GP Forward View back in 2016 to recruit an extra 5,000 GPs by 2021.

GP Online has now reported that a major international recruitment drive that aimed to recruit 2,000 GPs managed to produce just 34 GP recruits in three years. The chances of improving on this have of course been systematically undermined by Brexit and the government's high profile "hostile environment" policy on immigration.

The Health Foundation report highlights the lack of any coherent government approach to the recruitment of professional staff from overseas, and in particular the need to include allied health professionals to the "shortage occupation list" since many of them earn less that the minimum £30,000 salary floor required to gain entry to the UK.



Crisis is the new normal – UNISON survey

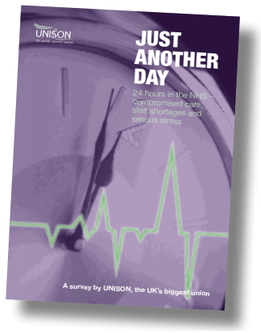
Crisis level staffing has become the norm across the NHS, according to a worrying new UNISON survey of over 16,000 staff.

The snapshot was based on just one working day – Tuesday September 18 – before any winter pressures added to problems.

Almost two thirds (59%) of 2,345 staff responding who worked in acute inpatient services reported that staffing levels were insufficient.

Almost half (45%) of mental health staff, 41% of primary care staff and more than a third (36%) of community health staff raised the same concerns.

Almost half of all the staff responding said that services relied on bank staff to fill



nursing roles and work as healthcare assistants, admin and clerical and other jobs.

Almost one in six (15%) felt patient safety was compromised by staff shortages on the day of the survey. 38% reported working longer than their scheduled hours, many of them unpaid, on the day of the survey.

Other responses help point to reasons for the problems recruiting and retaining vital staff.

One in six (16%) of the staff in all posts reporting being subjected to violence, aggression or verbal abuse on the day of the survey, and more than a quarter (26%) reported high levels of stress.

UNISON is calling for legislation to ensure mandatory safe staffing levels in England and Northern Ireland, following on similar measures that have been implemented in Wales and broadly similar proposals being passed through the Scottish parliament.

Counting cost of lost bursaries

The Royal College of Nursing is also pressing for a legal enforcement of safe staffing levels.

It has highlighted the long-term damage caused by the government's short-sighted effort to save money by axing NHS bursaries for the training of nurses and other professional staff which is now beginning to show through.

The RCN has revealed that nursing degree applications are down by a massive 30% since 2016 – the last year students received the bursary payments.

2018 was the second year in a row in which numbers of applications fell.

The largest decline in numbers is the 41% reduction in applications from mature students (aged 25 and over).

Across the UK almost a quarter (24%) of students starting a nursing degree dropped out or failed to qualify within the expected time.

Mature students, most of them returning to learning after some years of employment, are most likely to complete the course – but also the most likely to require bursaries to help support families and compensate for loss of earnings.

Brexit blow to social care

Problems recruiting sufficient staff to deliver social care services are likely to increase sharply with Brexit according to the Association of Directors of Adult Social Services (ADASS). One sixth of the 1.3 million workforce in social care come from overseas, comprised of an estimated 100,000 EU nationals and another 100,000-plus non British workers.

In a letter to London's *Evening Standard* ADASS point out that the proposed £30,000 minimum salary level for migrant workers to be allowed in to Britain would effectively block entry to new recruits and leave nursing homes and domiciliary care companies struggling to keep services running.

The problem is of course worsened by the absurdly low levels of pay prevalent in social care services.

Insulin users at risk in no deal Brexit

This month as seen an impassioned call from a diabetes charity to the government to guarantee the supply of insulin in the event of a crash-out Brexit.

The InDependent Diabetes Trust says the government is "gambling with people's health" as Brexit could severely impact on the availability of insulin supplies - this is a life or death situation for the thousands of insulin-dependent diabetics in the UK."

Insulin has hit the headlines as nearly all supplies in the UK are imported, mainly from Denmark. The drug needs to be refrigerated and cannot be kept waiting in traffic jams at ports.

If the UK crashes out without a deal in a few weeks time, there are real concerns over supply.

Without insulin diabetic patients could be dead within 48 hours.

Jenny Hirst, co-chair and co-founder of the organisation, said:

"While everyone is getting sick of the whole Brexit debate, insulin-dependent people with diabetes will actually become seriously ill if a no-deal disrupts supply of the life-saving drug.

"MPs need to realise that they are gambling with people's health. The party political games, the Tory euro infighting, the jousting for the top jobs, it all needs to stop. They all just need to come together to agree a deal to avoid any disruption to essential supplies."

Hardcore Brexiteers dismiss it all as propaganda generated by "project fear" Europhile campaigners. They have said the UK can just import from the USA or elsewhere.

This of course, does not take into account the difficulties that will be faced at ports amidst the chaos of the predicted lorry queues or the requirement for a specific type of insulin.

Right to worry

Mark Dayan, a policy analyst at Nuffield Trust, told the ***Washington Post***, that government preparations "would probably prevent … really widespread shortages immediately."

Still, he said, "People are probably right to worry."

Also, for diabetics one insulin cannot simply be swapped for another; there are several types. Each patient has a particular treatment regime, involving different devices and types of insulin.

Each regime is finely-tuned to regulate the patient's blood glucose levels to ensure the health of the patient. The development of the patient's regime can take months or even years to perfect. It cannot be changed at a moment's notice without harming the patient's health.

There are concerns for many drugs used by the NHS; about half are imported from or "have some touchpoint with the EU", according to the Health and Social Care Secretary Matt Hancock.

He should know: he claims his department have been through line-by-line analysis of the 12,000 licensed medicines in the UK. Last month he made it clear to the Health and social care Select Committee that medicines will take priority over food in a no deal Brexit scenario.

Private digital GP service given go ahead to attract more NHS patients

Paul Evans

Digital GP services run by private provider Babylon have been given the green light to expand into Birmingham and add to the 40,000 NHS patients that it has so far recruited from its West London base.

In a U-turn NHS England has lifted its block on the company expanding the service. It was imposed following complaints from local CCGs that the digital GP service was cherry-picking younger, fitter patients and undermining other local services.

Babylon GP at Hand provides video appointments with a GP within 2 hours and diagnosis tools though its own app. It is not suitable for many patients who need face-to-face care, but has proved attractive to younger NHS patients and 40,000 have signed up, leaving their local GP.

Permission from NHS England to extend the service appears to pre-empt the publication of an independent review into GP at Hand, which it commissioned and is due to be published in March.

Concern has already been voiced that investigations into the service are not robust enough.

Researchers IPSOS MORI admitted in a preliminary report that they would not be able to fully evaluate the safety and effectiveness of the service.

BMA GP Committee chair Dr Richard Vautrey told *Pulse*:

'We are incredibly disappointed with this decision, which is not only premature, but flies in the face of place-based care delivered by practices embedded in local communities, which the recent changes in the GP contract are committed to deliver.'

Babylon has welcomed the decision and hinted at further plans to go countrywide with their digital GP service.

Under the government's GP choice scheme patients are able to apply to register with any participating GP practice away from home. Figures from NHS England show that most practices have no out of area patients at all. Babylon are using the scheme to compete for NHS patients, registering tens of thousands of new patients as 'out of area'.

The Health Secretary, who is himself signed up to the GP at Hand service has made digital solutions a key priority, but has been criticised for appearing to offer his personal backing to Babylon, which Labour suggests breaks the ministerial code.

Prior to this week's announcement it had appeared that Babylon's plans were being curbed, as recent rule changes restricted the rewards that the company could earn for registering new patients.

However, the permission to extend the service has invited new criticism that the digital service is being unfairly supported by the government.

According to reports in the *Telegraph* Babylon Health already has plans to expand GP at Hand into Southampton, Manchester and Leeds.

In Birmingham the clinical Commissioning Group that had originally objected to Babylon is now backing the service. Paul Jennings, the CCG's chief executive told *Digital Health*:

"Working in close collaboration with our GP provider organisations, we are supporting the development of a local digital offer that will help to transform the lives of our 1.3 million patients."

Q&A: Who is Babylon Health
and what is it doing within the NHS?

Babylon Health has made headlines in recent months through its work within the NHS on developing digital technology and the use of its GP at Hand smartphone app.

By Sylvia Davidson

Who started the company?

Babylon Health was founded in 2013 by former investment banker Ali Parsa, who until December 2012, was CEO of Circle Health. Circle Health was the private company that was awarded a ten year contract to run Hinchingbrooke Hospital in 2012 and abandoned it three years later in 2015.

What technology has Babylon Health developed?

The company has developed a smartphone app which is designed to answer medical queries through the use of a question and answer format. The app can then put the user in-touch (virtually) with a GP. Babylon says the technology is a form of artificial intelligence (AI).

The app can be personalised by the use of a dashboard of the user's health statistics (exercise regime etc.) acquired either by the phone or via supplemental devices. Babylon will supply users with blood testing kits for liver and kidney function, thyroid function, vitamin levels, bone density and cholesterol. The results of the tests are then incorporated into the user's app settings.

In the UK, the company also offers a private service via its app; the service has a subscription charge plus extra costs on top, such as £25 for a remote GP consultation.

Babylon's primary target in the UK, however, is gaining access to NHS patients. The company has a contract with NHS England for its app under the name GP at Hand. The service was launched in London in 2015 and expanded in 2017. Over 40,000 patients are now registered with the GP at Hand app.

What does Babylon Health do in the NHS?

Babylon Health has a contract with NHS

England to register patients to the GP at Hand app. The contract is through the GP surgery of Dr Jefferies and Partners, based in Lillie Road, Fulham in West London. All patients who sign up with GP at Hand are registered at this Fulham surgery.

If patients registered with GP at Hand need to see a GP or nurse in person they must make an appointment at the Lillie Road, Fulham surgery or at one of four other surgeries in central London.

All patients who sign up with GP at Hand must de-register from their own NHS surgery and re-register with the Fulham practice. Under the Government's 'GP Choice' scheme, this surgery can sign up patients outside its traditional boundaries.

As a result, Babylon has been able to target patients who live across London and those who work in zone 1 to 3.

Since the company began its NHS England contract, over 40,000 patients have registered at this single Fulham surgery. The company promises that patients will be able to 'book an appointment within seconds' and have 'a video consultation with an NHS GP typically in under two hours of booking, anytime, anywhere'.

Initially, GP at Hand could not register certain groups of patients, but in November 2018, NHS England lifted all restrictions on the type of patient that can register with GP at Hand.

In February 2019, NHS England cleared the way for GP at Hand to expand to Birmingham. Patients who sign up in Birmingham will also be registered at the Fulham surgery in London, although the company will have a physical clinic in Birmingham.

What concerns surround Babylon Health?

Cherry-picking

Both the RCGP and BMA have criticised Babylon for 'cherry picking' younger, healthier patients, leaving other GP practices to deal with patients requiring more complex care.

GP at Hand can be used by all patients, however this type of digital service is more likely to appeal to a younger, fitter, healthier demographic and is unlikely to be used by older patients with complex needs.

This cherry-picking of healthier patients is an issue due to the way GPs are paid. GPs are paid per patient and rely on risk pooling and cross subsidy in that the fee for their younger fitter patients, who consult less often, subsidises the more expensive care for the more complex and elderly patients.

A report in November 2018 by GP Online confirmed the predictions that the GP at Hand service will attract younger, fitter patients. It found that in April 2017, 16% of patients at GP at Hand's Lillie Road surgery were aged between 20 and 29 years old, but by November 2018 this had risen to 49%.

Of the 31,519 new patients who had signed up with GP at Hand over the previous 12 months, 87% were aged between 20 and 39 years old. Patients that are over 65 now made up just 1% of the population registered with the service – compared with around 10% in April 2017.

Destabilisation of local health economy

In March 2018, Pulse reported that the success of GP at Hand was leaving the local health commissioners, Hammersmith & Fulham CCG, with a deficit. The influx of patients from across London has increased the CCG's costs significantly. Within a short space of time the CCG has around 40,000 more patients than it budgeted for. In May 2018 the CCG reported that it would need an additional £18 million in extra funding to cope with the influx of patients.

In January 2019, Hammersmith and Fulham CCG reported a deficit of £2.5 million. The CCG stated that Babylon's GP at Hand is the 'key driver' of cashflow issues. The CCG has noted that as Babylon continues to run advertising campaigns across London for new patients things are likely to get worse. The CCG has also noted that the costs associated with the Babylon GP at Hand practice could 'jeopardise' other health and care services in the area.

Deskilling of GPs

There are concerns about the effect on GP skill levels; GPs that move to work for Babylon will not face the great variety of cases seen in a normal practice. In particular, the GPs will lose skills in the area of care of the elderly and frail and in mental health.

Referral Problems

In mid-2018 it came to light that there were issues with referrals by GP at Hand for mental health services and community care outside of the Hammersmith & Fulham CCG area. GP at Hand was referring patients to services within their own CCGs, closer to where they actually lived. However, other London CCGs and providers said they were unable to accept these referrals.

After Hammersmith and Fulham CCG intervened and agreed to pay for the patients' treatment, most neighbouring CCGs and services agreed to accept referrals.

However, this now leaves Hammersmith & Fulham CCG having to pay for a large amount of out-of-area treatment. This is a major driver of the deficit that Hammersmith & Fulham CCG has accumulated (see destabilisation of the health economy).

Performance concerns

Babylon Health is very positive about the capabilities of its GP at Hand app, claiming that it has outperformed doctors and nurses. Others are not so positive.

An anonymous NHS doctor who tweets under the name @DrMurphy11 has tested the Babylon app repeatedly, highlighting problems, including when he posed as 48 year old, 40 a day male smoker who wakes "with a shoulder pain radiating down his arm" – the Babylon app told him his symptoms could be managed at home with a cold compress and painkillers, when a heart attack should have been considered.

Dr Murphy has a series of tweets known as the 'bad bot threads' that highlight the issues with the Babylon Health App.

In July 2017, an inspection of the GP at Hand service resulted in a critical report, which raised concerns about the potential for prescription misuse and lack of information sharing with a patient's primary GP.

However, the report also stated that most services "were safe, effective, caring, responsive and well-led."

Babylon Health tried to suppress the publication of this report, taking the CQC to the High Court in December 2017. The high court ruled that the report could be published; Babylon then criticised the CQC and questioned whether the regulator has the ability to regulate digital health services. In late December 2017, Babylon dropped the legal case against the CQC and agreed to pay £11,000 in legal costs.

Misleading advertising

In October 2018 the Advertising Standards Authority (ASA) upheld complaints about Babylon Health's adverts on the Underground in London.

The complaints were that the ads were misleading because they did not make clear that in order to use the services advertised consumers must leave their current GP; and the GP at Hand service, including its in-person consultations, was only available to consumers who lived or worked in the catchment area of specific GP surgeries.

The complainants also challenged whether the claim

Other firms like HCA (right) are now moving into the market offering "private GP" services for the worried wealthy, but GP At Hand is siphoning funds from the NHS

"See an NHS GP in minutes" in the ads was misleading. The ASA told Babylon Health that the ads must not appear again in their current form.

By January 2019, six other complaints made to the ASA regarding Babylon Health's advertising had been resolved informally, according to the ASA website.

Does the Government support Babylon Health?

Well Babylon Health certainly has a supporter in the Health and Social Care Secretary, Matt Hancock, who is himself a subscriber to GP at Hand.

Matt Hancock has, what seems to many, an inappropriately close relationship with Babylon Health. In September 2018, Mr Hancock gave a speech at Babylon's headquarters in which he told an audience of Babylon Health staff he wants to help the company expand "so loads of companies can come do what Babylon are doing" in the NHS. And in November 2018 Mr Hancock praised the company in a paid-for article in the *Evening Standard;* the Labour Party says this broke the ministerial code and has demanded an enquiry.

What is the financial background of Babylon Health?

The company has a complicated structure with several companies registered at UK Companies House. However, the operating company is a subsidiary of Jersey-based Babylon Holdings Ltd.

The ultimate controlling party is ALP Partners Ltd, a company run by Nedgroup Trust on behalf of the Parsa Family Trust. This company is based offshore.

Who has invested in Babylon Health?

Babylon is funded by private equity. It has undertaken two rounds of funding: in January 2016 Babylon raised $25 million and in April 2017, the company raised $60 million.

Lead investors include the Swedish investment group AB Kinnevik; Demis Hassabis and Mustafa Suleyman, the founders of DeepMind, the British artificial intelligence company acquired by Google; Sawiris, an Egyptian billionaire business family, NNS holdings, and Vostok New Ventures.

In February 2019, the FT reported that Babylon Health was seeking to raise $400 million for ongoing expansion.

Bed shortages hit A&E and elective care

Official figures show that despite the relatively mild winter and limited spread of flu this winter, waiting times in A&E last month were the worst since the 4-hour target to treat, admit or discharge 95% of patients was established almost 15 years ago. Only two out of 134 major A&E units hit the 4-hour target.

Overall just 84.4% of patients were seen in the target time in January: but more worryingly the situation is much worse for the most serious "type 1" A&E patients, where on average just 76.1% of patients were seen within 4 hours, and the worst-performing trust, Croydon, fell below 50% for the first time.

Emergency admissions via A&E have kept increasing, and topped 421,000 in January, up 8% on January 2018.

The delays were often driven by lack of beds and problems moving patients through the system, leaving over 13,500 ambulances delayed for over 30 minutes in handing over patients in the first week of February, 26% up on last year.

Dr Taj Hassan, President of the Royal College of Emergency Medicine told the *Independent* "The need for more beds could not be clearer."

The pressure on emergency services has had a knock-on effect on waiting times: more than 13% of patients waiting over 18 weeks for treatment in December, the worst since 2009. The 62-day target for 85% of patients to begin cancer treatment after an urgent referral was last achieved three years ago.

The Royal College of Surgeons has also blamed bed shortages and cancellations of elective operations for a drop of 70,000 in numbers of treatments in 2018 comparted with 2017.

Since 2014 there has been a reduction of 200,000 elective operations carried out by the NHS in England.

Consultants expose Norfolk underfunding

John Lister

A devastating 'Demand & Capacity Review' analysing the problems facing acute and community services and primary care in Norfolk and Waveney's Sustainability and Transformation Partnership (STP) has been compiled by the Boston Consulting Group at a cost of £500,000.

It has exposed the shallowness of the STP plan drawn up in 2016. It also underlined the fundamental under-funding of local services and the need for more beds in all three acute hospital trusts, two of which are currently rated as "inadequate" by the Care Quality Commission.

The report pulls no punches, pointing out that the "fragmented commissioning landscape" (which of course was worsened by the 2012 Health and Social Care Act) is under financial pressure.

Despite rhetoric at the end of last year about Norfolk and Waveney being an "aspirant integrated care system," there are only limited plans for integration.

If things stay as they are the STP area could wind up with a £140m deficit and a shortage of 500 beds by 2023.

Moreover in moving towards any coordination and strategic planning, say the consultants, the local NHS is "starting from behind". Across the STP area there will likely be a £95m in-year deficit in 2018/19.

Indeed the largest acute trust, Norfolk & Norwich University Hospitals, which last year rejected NHS Improvement proposals for a "control total" of a £10.7m surplus and opted instead to aim for a £55m deficit, is now having to revise that figure upwards, and in January projected a deficit of £58.8m for the year.

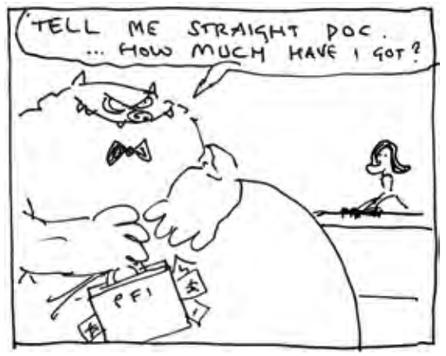
PFI cost burden

The report states that making matters worse is the fact that the Norwich Trust is "carrying a significant PFI cost, contributing to a structural deficit".

Boston Consulting argue that "All hospitals see high volumes of non-elective work," not least as a result of "excess demand" for primary care of 9%, and a declining GP workforce, which they say contributes to higher levels of demand for emergency hospital care.

There is a severe pressure on bed numbers, with hospitals swamped with emergency admissions: "Non-elective demand is growing 4-8% and will fill available elective capacity within 2-3 years."

"Non-elective demand is growing 4-8% and will fill available elective capacity within 2-3 years."



However there is also a problem of inadequate services outside hospital, resulting in large numbers of "Medically Fit For Discharge" (MFFD) patients occupying upwards of 160 beds in the three acute trusts.

Boston Consulting argue that if a series of interventions across the whole local NHS were successful "a total of 180 beds could be freed"

However this would require the transfer of 130 beds "or bed equivalents" into the community – and would require investment and of course workforce to deliver.

Even if all this were done, the prospect is that 120 more acute beds would be needed by 2022/23 – 85 of them in the crowded Norfolk & Norwich – and 20 more beds in Norfolk Community and Health Care trust.

Boston Consulting calls for steps to ensure the three acute trusts are enabled to collaborate together rather than compete:

"The acutes must now build from what they have already achieved, mobilise as a collective and work towards clinically led, integrated approaches to care delivery."

Although many of its proposals seem over-optimistic, and the focus excludes any discussion of mental health services other than within primary care, this consultants' report does break from the norm, by offering a brutally frank assessment of the situation, and at least attempting to take account of the full cost of the measures necessary to enable health care providers to cope.

In other areas more evasive reports are failing to get to grips with the scale of the problems.

The Lowdown will continue to follow this and similar far from integrated health systems as they assess the possibilities of moving towards "integrated care" as required by NHS England's Long Term Plan.

£6 bn bill for repairs

Backlog maintenance bills across England's NHS have now reached almost £6 billion, with more than £3 billion of this linked to "high risk" or "significant" issues, according to the latest available figures.

Six of the ten largest problems are in London – four of them in North West London (Charing Cross, St Mary's and Hammersmith Hospitals (all part of Imperial Health Care Trust, combined bill £649m) and Hillingdon (£80m).

St Helier Hospital's bill (including "moderate" risk is over £75m, and Whipps Cross Hospital (part of Barts health) has bills of £44m.

Other large bills include Doncaster with a total bill of £67m, and Nottingham University Hospitals, which faces a combined bill of £104m including a massive £77m backlog at Queen's Medical Centre. Medway Maritime Hospital in Kent has a combined bill of £58m.

The problem has grown as a result of year after year of siphoning off capital allocations to prop up revenue budgets and reduce the declared deficit.

The NHS definition of its high-risk repairs are those that "must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution".

Lack of cash brings certainty to Watford – but no new hospital for Hertfordshire

A public meeting in Hemel Hempstead on March 7 will be given the latest information on long-running plans to reconfigure hospital services in West Hertfordshire.

This comes after doubts over the future of Watford General Hospital (pictured above), and the possibility of it being replaced by a new acute hospital to be built in a more central location to cover West Hertfordshire, have been ended – by the lack of NHS capital and revenue funding.

Initial plans costing £600-£800m for the redevelopment of Watford General and St Albans City Hospital were rejected by NHS Improvement: two subsequent petitions with over 20,000 signatures between them then demanded a new acute hospital be built.

At the end of January a public meeting in Watford of over 160 people convened by the West Herts Trust and Herts Valleys CCG heard that (contrary to the CCG's subsequent misleading headline claiming that "We're closer than ever to securing funding for our hospitals") this too has now been rejected as unaffordable.

NHS Improvement has decided that the amount of capital available will be linked with the West Herts Trust's annual turnover of £350m; they have told the Trust that they on't be allowed to access private finance or phase the cost of any hospital plan.

The option of moving emergency care from Watford has been ruled out "because it would require many other interdependent services to also be relocated and would therefore cost too much."

The option of moving emergency care from Watford has been ruled out because it would cost too much.

Worse for those impatient to see investment in improved buildings and services, the CCG and Trust won't find out until the autumn spending review how much money they might be able to secure in capital funding

They have a few months to draw up a plan, but then can only hope for the best.

All three main options now centre on the West Herts trust (which has a catchment population of more than 500,000 and a target of limiting its deficit this year to £52.9m) retaining its main emergency and acute services at Watford General.

In addition to this there is the question of whether to develop Hemel Hempstead Hospital for medicine and St Albans City Hospital for surgery, or centralise all planned care at either Hemel Hempstead or St Albans hospitals – or replace both sites with a new planned care centre hospital.

Local health campaigners pointed to the poor state of repair of all three hospitals and the prospect of a substantial increase in local population putting more pressure on limited capacity.

However as might be expected the Trust's acting chief executive Helen Brown, was determined to put a positive spin on the situation, insist:

"We have a fantastic opportunity to transform services and deliver urgent and much-needed improvements to our hospital buildings."

What the (research) papers say

Flawed assumptions lead CMA to false conclusions on mergers

John Lister

NHS England's Long Term Plan, published last month ends with a plea to government to repeal or amend the law to relieve commissioners of the obligation to put services out to competitive tender, and create a legal basis for the proposed "Integrated Care Systems".

As we noted in our first pilot issue, this appears to have gone down like a lead balloon with ministers, who have not even taken the simple steps open to them to revise or scrap the regulations governing the implementation of Andrew Lansley's Health and Social Care Act.

The Act itself had to be laboriously pushed through by Tory and Liberal MPs, but the regulations, as secondary legislation, can be changed at the stroke of a ministerial pen.

One of the many unwelcome new developments brought in by the 2012 Act was to establish a role for the CMA (no, not the Country Music Awards, but the Competition and Markets Authority) in scrutinising proposed mergers of hospital trusts to ensure that they did not eliminate competition between trusts and "patient choice" in their immediate area.

Supermarkets

The CMA (formerly the Monopolies and Mergers Commission) is most used to dealing with mergers in the private sector – bus companies and supermarkets, etc.

They clearly don't understand the values or the workings of the NHS. But this level of ignorance has not stopped them taking up the cudgels – as few have seriously attempted for the past 7 or 8 years – to argue the case FOR competition between hospitals … and therefore implicitly AGAINST NHS England's current obsession with "integration" and collaboration.

They have just published an almost impenetrable 52-page report Does Hospital Competition reduce rates of patient harm in the English NHS? It rehashes many of the lame old arguments in favour of competition, and then invents some more, with the aid of some complex mathematical formulae and densely worded arguments, using obscure language and a proliferation of baffling acronyms.

"Our main estimate is that a hypothetical future merger between two geographically proximate hospitals would, on average and assuming no offsetting clinical benefits are unlocked by the merger, result in a 41% increase in harm rates."

Astounding

It comes to an apparently astounding conclusion:

"Our main estimate is that a hypothetical future merger between two geographically proximate hospitals would, on average and assuming no offsetting clinical benefits are unlocked by the merger, result in a 41% increase in harm rates." (emphasis added)

Of course the use of the percentage in this statement is somewhat misleading since the overall mean "harm rate" is calculated at 1.9% of patients suffering harm (page 14). A 41% increase in this would increase the harm rate to 2.7% (i.e. 27 patients per thousand patients treated).

While any avoidable risk to patients must be minimised, many might still regard this as evidence of a relatively safe system. We have, of course no counterfactual estimate of what the harm rate might have been had existing merged hospital trusts not merged.

But if the CMA really thought the findings were as dramatic as they appear to be in this document, surely they should be right now insisting that NHS England drop its plans for integrated care, and all outstanding hospital mergers should be blocked.

Ironically many of the hospital mergers that have been taking place have done so arguing that concentration and centralisation of specialist services was essential to ensure patient safety and safe staffing levels. It will no doubt come as a shock to many trust bosses and commissioners that the CMA has formed such a negative view of the plans they propose.

Prior conviction

NHS England chair Lord Prior for example only a few days ago gave a speech to the neoliberal fundamentalists of Reform in which, according to *The Times*, he argued that "targets, competition and reliance on inspectors" had all led to "a disjointed system and demoralised staff."

Prior laid the blame at the door of "a series of NHS reforms."

These were of course carried through since 1989 by his own Tory political colleagues (and by New Labour from 1997). Now he says that that have "broken up the health service into autonomous hospitals," making it "almost impossible" to drive an integrated strategy across the NHS.

"You could not have designed something that had at its heart more dysfunction. It's truly remarkable."

Many of us who opposed these changes over the years have argued precisely this same point.

Who would have guessed that former Lehman Brothers banker and Conservative Party Chairman Prior would now reject competition (and by implication also privatisation) in the NHS, putting himself at odds with 30 years of government policy?

Now the CMA tells us that the more competition the better, and that integration is a threat to the quality of care.

There are many more questions to be asked about the assumptions made by the CMA.

Time warp

The report was published at the end of January, but appears rooted in a bizarre time warp, relying on ancient data (2013-2015) and reviving old arguments seldom heard this decade. It seems committed above all to the New Labour notion of competition as a way to offer patient choice.

Competition between rival firms failed lamentably to improve hospital cleaning

New Labour experimented with the establishment of "Independent Sector Treatment Centres" (ISTCs), which were contracted to deal only with the simplest elective cases (although initially at higher cost than NHS trusts).

Many of these contracts have subsequently ended, but the CMA appears to regard any private hospital treating NHS patients as an ISTC.

They claim, without citing any evidence, that ISTCs' "significance has grown in recent years".

In fact most of the private providers by 2016/17 not ISTCs but private hospitals. A total of 217 privately-run for profit and non-profit hospitals and clinics handled a total of just under 550,000 waiting list patients – (8.6% of the total of almost 6.4 million), and treated 431,000 out of 7.1 million day cases (6%).

The private share of elective work is no longer growing. Spending on "independent sector providers" in 2016/17 was just over £9 billion: but the following year this level of spending fell, both in cash terms and as a share of NHS spending.

Uptick

The CMA notes consolidation of trust numbers through mergers in the late 1990s, but claims "the number has since remained fairly static," although it does note an "uptick" in numbers considering merger as a result of recent financial pressure on the NHS.

Indeed mergers have continued. In 2014 according to the NAO there were 244 trusts (97 NHS trusts and 147 foundation trusts): but the latest lists show just 227. In 2016, an HSJ article reported that one in three acute hospital trusts were "set to merge, join chains or form alliances": some of these are still proceeding.

In many areas plans are being pushed forward to downgrade services and centralise specialist services, further reducing any possibility of competition.

The report was published at the end of January, but appears rooted in a bizarre time warp, relying on ancient data and reviving old arguments seldom heard this decade

Capacity constraints

Yet the CMA still talks about hospitals competing to attract more patients (p7) glibly suggesting that capacity constraints, sky high levels of occupancy of available beds, and staff shortages that bedevil so many NHS trusts can easily be addressed by "reducing length of stay and managing beds more effectively, by investing or by innovating".

To confirm how out of touch they are, the CMA report adds outdated statistics – from a bygone age before the current financial pressures and bed shortages: "over 92% of patients … were seen within the 18 week referral to treatment target **between March 2012 and March 2015**." (emphasis added).

Targets missed

Today's situation is very different. The referral-to-treatment target has not been met since February 2016, and the proportion of people waiting over 18 weeks to start elective treatment reached 13.4% in December 2018 – the worst level of performance since January 2009.

Hospital trusts are in no position to compete for extra patients: they are struggling to handle the workload they have.

The CMA then throws in page after page of highly technical and statistical calculations – all based on just 2 years of data (2013/14 and 2014/15). The calculations, for what they are worth, therefore relate only to that period, rather than now.

The CMA appear blissfully unaware that since 2016, with the development of Sustainability and Transformation Plans the main debate has moved on: competition is yesterday's big idea.

Their whole approach is based on outdated theories and assumptions rather than current reality. Perhaps that's why the CMA has published the report, but not coupled it with any announcement it will ban all future mergers to avoid the claimed 41% increase in rates of harm to patients.

Tempting though it may be for some campaigners to invoke the CMA's warnings of potential harm from hospital mergers, it's best to steer well clear of this ill-conceived and deeply flawed report.

It has proved the irrelevance and ideological preoccupation of the CMA, and shown why it can never be a useful ally for those fighting for NHS values.

Dorset hits back against closures

Controversial plans for a so-called Integrated Care System in Dorset are being touted around the country by NHS bosses keen to show ICSs can improve services: last week they were quoted in a meeting of Warwick County Council by health bosses trying to win support for an ICS in Coventry and Warwickshire.

The plans seem more convincing and adequate the further people are from Dorset.

Those extolling the virtue of the Dorset plan are not so keen to mention that they involve the "centralisation" of A&E and maternity services in Bournemouth in the far east of the county, and downgrading Poole Hospital to a "cold" site delivering only elective surgery.

Dorset County Council's health scrutiny committee, unconvinced by the CCG's proposals and concerned at figures showing the potential threat to lives of emergency ambulance patients facing longer journeys from much of the county, voted last November to call on Health Secretary Matt Hancock to refer the plans to the Independent Reconfiguration Panel – the independent expert on the NHS – for full scrutiny.

The plans from Dorset CCG also involve a cutback in community hospital services, and this has triggered further protests, with 200 campaigners surrounding Portland Hospital to protest at the proposed closure of its 16 beds to move them to Weymouth.

Westhaven hospital might be just 5 miles from Portland, but it's a 45 minute journey each way by public transport, and campaigners are less than enthused by promises the building could be turned into a "health and wellbeing hub".

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 (129,835) 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

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 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.

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

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

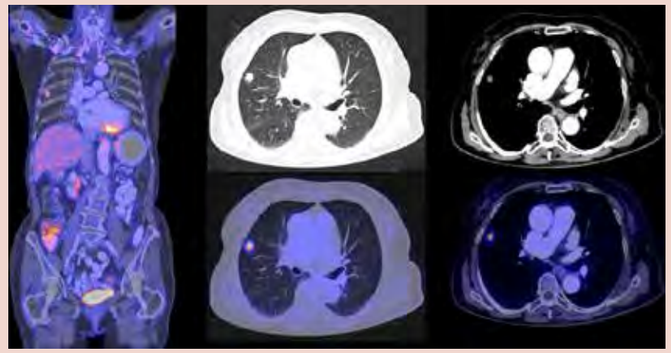
The contract leaves open the chance for private companies to take on the lead role, although a report by the Health Select committee judges that this looks unlikely in practice.

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.

"I thought my vote for Brexit would only affect the people back home in the UK ..."

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.

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.

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

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?

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

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"

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

THE lowdown

Health news, analysis and campaigns.
PILOT ISSUE #4
March 23 2019

Informing, alerting and empowering NHS staff and campaigners

The Rotherham NHS Foundation Trust

14th March 2019

Dear colleagues

On behalf of the Board of Directors, I wanted to provide you with an update on the current position regarding the Wholly Owned Subsidiary.

As you are aware, in September 2018, the Trust had planned to consider the establishment of a Wholly Owned Subsidiary (WOS). However, in the previous week NHS Improvement (NHSI) had issued a general communication to all trusts which outlined their intention to review the regulatory approach to subsidiary companies.

The regulator had further requested that any plans to create new subsidiaries should be paused until the regulator had concluded its consultation on the proposed approach. New guidance would be issued thereafter.

As a result of this communication, it had been decided not to consider the WOS business case at that time.

Over recent months we have been looking in detail at the guidance which was issued. After further consideration, the Board of Directors have now taken the decision not to progress the business case.

I would like to thank you all for your continued patience and commitment throughout this time.

If you have any immediate questions, please direct these to your line manager or to the Communications Team at [redacted]

Yours sincerely,

Rotherham staff roll back another WOC

Rotherham UNISON health workers are the latest to join a lengthening list of branches that have successfully resisted efforts by their trust management to hive them off into "wholly owned companies" (WOCs).

A letter on behalf of the Foundation Trust board on March 14 stated formally that they have decided not to proceed further with the controversial Business Case that would mean staff no longer being NHS employees – and reliant on the flimsy protection of the TUPE arrangements for the continuation of their terms and conditions.

UNISON General Secretary Dave Prentis has written to congratulate the Branch.

At last! NHS strips Capita of cervical screening contract

Capita has finally been stripped of its contract to run the cervical screening contract in by NHS chiefs in England after failings. The service will be brought back in-house from June this year.

The news was announced in front of the Public Accounts Committee by Simon Stevens, NHS England CEO, who said he was not 'satisfied' with the way the company had run the service.

Last year, Capita failed to deliver nearly 50,000 letters to women about their smear tests – but neglected to tell NHS England about the error for two months.

The cervical screening service is part of the huge £330 million Primary Care Support Services contract, that Capita was awarded back in 2015.

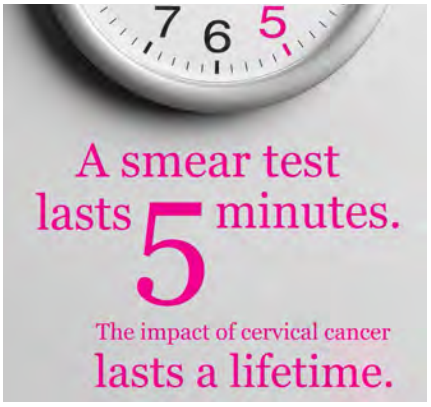
Since they took over the services, there has been a regular stream of reported problems. Issues with the cervical cancer screening programme are amongst the most recent to come to light.

Failures have ranged from surgeries running out syringes and prescription pads to more serious problems with the secure transfer of patient notes around the country,

Notes have reportedly gone missing or have been delivered to the wrong surgery. The administration of pensions has also been mishandled and the problems have affected GPs, dentists, opticians and pharmacists.

The National Audit Office (NAO) concluded that Capita's failures in running the contract meant that patients had been "put at serious risk of harm"

Capita failed to deliver nearly 50,000 letters to women about their smear tests – but neglected to tell NHS England about the error for two months.



The NAO had also recommended that NHS England should determine whether all current services within the contract are best delivered through that contract or whether they should be taken back in-house.

Colenzo Jarret-Thorpe speaking on behalf of Unite, who represent biomedical scientists working in the cytology service, had also asked the Secretary of State to step in.

"There are already several months in backlogs in patients receiving their cervical test results. This is traumatic for patients and is caused by not just the extra demand for cervical screening, but also the shortage of scientific staff who conduct the tests."

Capita's finances are not in good shape and the announcement of the loss of the cervical screening programme will not help confidence in the company.

The company has just announced a 26% fall in profits to £282.1 million in 2018 and revenue down 5% to £3.87 billion.

IN THIS PILOT ISSUE

10,000 dying patients never receive the care package they need, says new report

Terminal failure

Terminally-ill patients in England are often being denied the chance to fulfil their wishes to die at home, due to failings in the Fast-Track system of care that allows them to leave hospital quickly, according to a report by the charity Marie Curie.

The charity has estimated that there could be as many as 10,000 patients dying in hospital each year while they wait for a package of urgent care which would mean that they can be cared for at home.

Under the National Framework for Fast-Track Continuing Healthcare (CHC) patients that are considered to be close to death are entitled to an NHS package of home care within 48 hours of an application being made.

For the report, Marie Curie obtained data from 149 CCGs via freedom of information (FoI) requests on Fast-Track CHC requests in the 2017-2018 financial year.

The investigation found that there is a wide degree of variation across England in how long a patient will have to wait for the package of care, with some patients having to wait up to 19 days in certain areas.

Missing target

Of the CCGs who provided data, Marie Curie reported that the majority were missing the two-day implementation period for Fast Track CHC. Only 23 CCGs (22%) reported implementing packages of care within an average of 48 hours of an application being made.

Among the poorest performing CCGs, there are a number who are only able to provide care to half, or even less, of the dying patients who are entitled to fast track care. While 17% of the CCGs reported that more than a third of their patients did not get the care they needed.

Katy Blackwood [CC BY-SA 4.0 (https://creativecommons.org/licenses/by-sa/4.0)]

Most of the CCGs could provide the care package within 2-7 days, but 28% of the CCGs reported an average delay of a week or more, of which eight had delays of more than 12 days, with two CCGs having delays of up to 19 days (Cannock Chase CCG and Camden CCG).

Matthew Reed, Chief Executive of Marie Curie, said: "The report paints a bleak picture….Any delays will inevitably lead to people dying in hospital before arrangements can be put in place.

"When time really matters, it's important that no-one is left in limbo and denied their wish to spend their last remaining days at home surrounded by loved ones."

When the number of delivered care packages is considered, the investigation found that there are some areas of England where more than half of the applications being made for Fast-Track CHC are not resulting in delivered packages of care.

Among the poorest performing CCGs, there are a number who are only able to provide care to half, or even less, of the dying patients who are entitled to fast track care.

This is the second year that the charity has carried out the survey and a comparison of this data with 2016/17 data found that the waiting time is getting worse, with fewer CCGs meeting the 48 hours guidance and substantially more falling into a delay of 2-7 days.

The reasons given by the CCGs for delays to care packages were various, including problems with the bureaucracy, such as poor paperwork, inadequate training in the system and CHC approval services only functioning monday to friday in office hours, however there is also a problem with availability of care in the community, with a lack of care home places and lack of suitable community care.

This lack of sufficient community care was highlighted by Marie Curie in research published in March 2018. This looked at the significant effect on A&E departments of inadequate community care for terminally ill patients.

The charity's data showed that there were over 1.6 million emergency admissions for people in the last year of their life in Britain in 2016, costing the NHS £2.5 billion and amounting to around 11 million days in hospital.

If community care is adequate, it is often possible to avoid emergency admissions to hospital for people in the last year of life. The charity warned that the cost of emergency admissions will rise significantly if nothing is done to improve community care.

Warning signs ignored

Reports over the past few years have highlighted how underfunding and lack of staff have made it difficult for nurses in hospitals to care for patients as well as they want to.

A February 2017 survey by Marie Curie found that more than two-thirds (67%) of nurses surveyed said they did not have sufficient time to provide high quality care to those dying patients.

And a September 2017 report from the Royal College of Nursing found that patients are dying alone on wards due to nurses not having enough time to care properly.

This was followed by a RCN report in May 2018 - Nursing on the Brink - which highlighted how staff shortages are affecting safe patient care.

As the shortages of nursing staff gets worse, with the King's Fund, Nuffield Trust and Health Foundation predicting 250,000 vacancies by 2020 and 350,000 vacancies by 2030, then it's inevitable that the treatment of terminally-ill patients in hospitals will suffer and it becomes more important that adequate care is provided in the community.

All-party challenge to NHS England's PET privatisation

The controversial NHS England decision to award a 7-year contract for PET-CT scanning services to private contractors InHealth rather than the local NHS trust has united MPs from all parties across the county in angry opposition.

And as the volume of criticism continues to grow, there are signs of mixed messages between ministers and NHS England, which is showing signs of seeking to climb down.

Challenged by Oxfordshire Council's Senior Policy Officer Sam Shepherd on whether the contract was a done deal, NHS England responded

"No we are not ready to sign any contracts on this lot just yet as we need to first complete any necessary public engagement that may be required and listen to people's views."

By contrast junior health minister Steve Brine, challenged on how the decision had been made without any local consultation appeared unrepentant in a written answer that claimed the decision had flowed from "a 30-day public engagement" … three years ago!

"The Phase II procurement proposals between January – February 2016 … was publicised on both NHS England's website and its Engage portal. …

"As this was a public engagement exercise it was open to all stakeholders, including patients and members of the public. NHS England is committed to ensuring that the public are involved in decision making.

"Where new service proposals would result in substantial development or variation, such as location change, further public involvement activities will be undertaken."

But he went on to argue that NHS England had been quite right "in accordance with established procurement practices, which ensure impartial decision making" not to consult with any stakeholder groups MPs during the procurement process.

His words will cut little ice with his Tory colleagues in Oxfordshire, or with local LibDem and Labour MPs, all of whom have written to question the decision and the way it has been arrived at.

Banbury's Tory MP Victoria Prentis has written to NHS England chief Simon Stevens expressing "extreme concern" that patient care would suffer, since the contract, and the consequent relocation of PET-CT services away from the main Churchill Hospital site with its specialist department would affect the possibility of multi-disciplinary meetings to review each patient's treatment.

"We are not ready to sign any contracts on this lot just yet as we need to first complete any necessary public engagement that may be required and listen to people's views."
– NHS England response to Oxfordshire county council

Fellow Tory Ed Vaizey (Didcot and Wantage) stressed his general acceptance of competitive tendering for medical service – but nonetheless argued patient groups had raised "troubling issues with the new provider".

Oxford East Labour MP Anneliese Dodds has written to NHS England chair Lord Prior demanding a halt to privatisation of PET-CT services.

Local GP Dr Helen Salisbury in a BMJ blog explained the longer term threat of the contract:

"Currently radiologists are part of a multidisciplinary team who discuss and plan treatment for patients. If the NHS does not provide the service, how will we train the next generation of specialist cancer radiologists?"

Medics in the Oxford University Hospitals trust have also spoken out strongly, arguing that the decision risks harming patients. Their stance seems to have eventually drawn endorsement from the trust's chief executive Bruno Holthof, who has also said he has concerns for "quality and safety" of the proposed contract.

With NHS England attempting to fly the flag of opposing the competitive tendering requirements of the 2012 Health and Social Care Act, such a row has come at an awkward and embarrassing time – the more so since this contract is just the first of 11 to be let for PET-CT scanning, in a process that has been led Arden-GEM Commissioning Support Unit.

A contract for similar services in South East London has been awarded to a consortium including South African-owned Alliance Medical along with King's and Guy's and St Thomas's trusts.

Hospital security staff vote to strike

Security staff at Southampton General Hospital, who are being attacked in the A&E department, will strike for eight days in their dispute over pay rates, sick pay, and safety concerns.

The plight of the 21 security staff, who are being attacked on a regular basis by members of the public either under the influence of drink or drugs, or with mental health problems, has attracted national media attention.

Unite, their union, said on March 20 that the strike days would be in April, May, and June, as well as starting an overtime ban on 5 April.

Unite said that neither the employer Mitie Security Ltd nor the bosses at the University Hospital Southampton NHS Foundation Trust had made any effort to resolve the dispute since the lack of adequate personal protective equipment (PPE), such as stab vests and safety restraints, was revealed earlier this month.

The security staff voted unanimously for strike action and industrial action short of a strike and will now strike for 24 hours on 5 April, 19 April and 24 May. There will also be a 48 hour stoppage starting on 3 May and a further 72 hour strike on 7 June. All the strikes will start at 00.01.

Unite lead officer for health in the south east Scott Kemp said: "The lack of urgency on Mitie's part to resolve these personal protection issues at the Tremona Road site is a disgrace.

"At present, if the security staff are injured at work, and if the resulting investigation finds in their favour, they get two weeks' full pay and then two weeks' half-pay. After that, it is the statutory minimum."

CQC sounds alarm on private ambulances

Sylvia Davidson

In a highly critical report released this month, the Care Quality Commission (CQC) has raised concerns over the use of private ambulance companies.

The CQC report Identified a lack of proper governance in private ambulance companies, including checks on references and driving licences, little or no staff training, highly variable standards in medicine management, and poor maintenance of vehicles and equipment. Many of the organisations checked did not understand what it meant to be regulated and what requirements were placed upon them, according to the report.

The CQC found cases of a private ambulance provider sub-contracting to an unregistered provider, "without understanding or recognising that it is unsafe and it is a risk".

The CQC is also critical of the commissioners of services, noting that commissioning decisions were being based on finances rather than quality and there were poor contract monitoring arrangements in place. The report gives an example of a large independent mental health provider who was commissioning an ambulance provider that wasn't even registered.

Private ambulance services were initially employed to provide patient transport services and non-emergency work, however an increasing number are now providing 999 responses to support trusts that are struggling at times of peak demand.

The NHS is paying out large sums of money to these companies, with one estimate by the GMB union putting the figure at almost a quarter of a billion pounds over three years. The CQC report shows that this money is often not being spent to the greatest advantage.

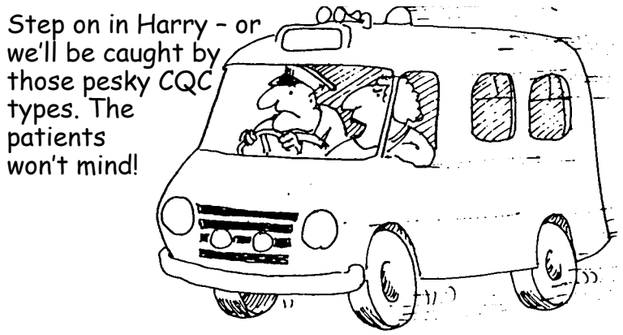
The level of private sector involvement in the ambulance service has been rising since 2012, with large contracts being advertised and awarded for non-emergency patient transport and more recently with emergency coverage included as well.

These contracts were awarded to a range of organisations, including well-known ambulance providers, such as St John's Ambulance and the Red Cross, but also to companies such as Arriva and taxi firms. Almost all non-emergency patient transport is now provided by private companies.

The disastrous Coperforma contract in Sussex is a prime example of how things can go very badly wrong with awarding services to a private ambulance company. The CQC report references this contract at the end, although it is not specifically named in the main report body.

This four year contract for non-emergency patient transport worth £63.5 million was awarded in 2015 by seven CCGs in Sussex to Coperforma. Under the contract, Coperforma acted as an intermediary sub-contracting out the ambulance work to private ambulance companies. Many of the staff working for the sub-contractors had transferred from SECamb after this organisation lost the contract.

Coperforma replaced the NHS's South-East Coast ambulance service (SECamb) on 1 April 2016 and it was then just a matter of days, before problems with the contract hit the headlines.



By mid-April local and national press were reporting on a service in chaos, with crews not turning up to pick up patients leading to missed appointments and patients languishing for hours in hospitals awaiting transport home.

Patients included those with kidney failure with appointments for dialysis and cancer patients attending chemotherapy sessions. The GMB union representing the ambulance crews said it was an "absolute shambles".

By August 2016 it was also evident that there were issues of payment to sub-contractors. VM Langfords was the first sub-contractor to go bust in June 2016, followed in September 2016 by Docklands Medical Services.

In October 2016 a third sub-contractor, Thames Ambulance, reported financial difficulties. The sub-contractors all blamed Coperforma, saying they are owed millions in unpaid invoices by the company.

The lack of payment to sub-contractors meant that many of the ambulance crew members had not been paid and were owed thousands in back pay.

Finally in October 2016, Coperforma was forced to give up the contract. Despite promising to transfer money to pay the ambulance crews, High Weald Lewes Havens CCG had to step in eventually and provide the money for the back pay.

In November 2016 the CCGs announced a managed transition to the NHS's South Central Ambulance Foundation Trust beginning immediately and with a final takeover in April 2017.

In December 2016, a report by Brighton & Hove's Healthwatch based on the experience of dialysis patients listed a litany of failures by Coperforma, including anxiety and stress due to failures of the service, transport failing to turn up and drivers who did not know the area and were inappropriately trained and equipped.

In early November it was revealed that the CQC had served six improvement notices on the company.

Other examples, include that of Thames Ambulance Service Ltd (TASL) which was stripped of its contract in North Lincolnshire in 2018 after its performance failed to improve. An inspection by the CQC in October 2017, led to a damning report in February 2018. The CQC uncovered a range of failings including one day when 13 patients were left waiting at hospital for transport.

In late September 2017, the private ambulance company, Private Ambulance Service contracted to run non-emergency patient transport from hospitals in Bedfordshire and Hertfordshire went into administration, with trading ceasing 9 October 2017.

The business, which had 126 vehicles and employed 300 people, had taken over the contract in April 2017.

By July problems had been reported with the service, including a report in the ***Herts Advertiser*** in July 2017 about Herts Valleys CCG issuing an apology after ongoing problems, including leaving vulnerable patients stuck in their homes or in hospital for hours waiting for transport.

Almost all non-emergency patient transport is now provided by private companies

Liverpool Hospital strike over pay

Liverpool Women's Hospital staff employed by the private company OCS are fighting for an extra £1 an hour.

The UNISON members – who work as cleaners, catering staff, porters and security officers – took strike action on March 11 after OCS refused to pay them the NHS rate for the job. OCS staff on the minimum wage are paid £1 an hour less than the NHS rate – which costs them up to £2,150 this year alone.

UNISON has recently learned that managers employed by OCS have seen their pay increase by more than 10% since the company took over the contract. Managers now enjoy salaries close to £50,000, while frontline workers are struggling to get by on the minimum wage.

New hope for patients needing organ transplants: but will there be enough staff to do the operations?

Paul Evans

A new law has been passed through Parliament that could save nearly 500 people a year who currently die because of a lack of available organ donors.

The new Act allows hospitals to presume that dying patients consent to donating their organs, as long as their name does not appear on a register of those that have opted-out.

This significant change will come into force in April 2020 and has been welcomed by medical bodies, unions and campaigners across the NHS.

There are 500,000 deaths a year in the UK, but only 1% of people die in ways in which their organs can be passed on and although 80% of the public agree in principle only 39% give consent in advance.

However, the news will add to pressure on struggling transplant and critical care services, casting doubt over whether the NHS will be able to take full advantage of the higher number of transplant opportunities.

A summit of transplant organisations has confirmed that they see a 20 to 25% increase in the number of transplants over the next five years as a big challenge. Currently the number of transplants is only rising at 1% a year - according to a report by the NHS Blood And Transplant Organ Donation And Transplantation Directorate.

A survey of transplant units found that 12 out of 17 are affected by staffing pressures and a lack of experienced staff.

The British Medical Association welcomed the change and has been lobbying for an opt out system for more than 18 years, but shared concerns about capacity.

Sue Robertson, Deputy Chair of BMA Scotland, told the ***Evening Times*** in Glasgow that,

"It is very important we have the infrastructure to deliver this, Intensive care beds, specialist nurses and enough transplant surgeons so the transplants can go ahead as speedily as possible…When you meet transplant surgeons you meet a bunch of tired people."

A survey of transplant units found that 12 out of 17 are affected by staffing pressures and a lack of experienced staff

The availability of critical care beds is crucial to the care of transplant patients and has already been pinpointed by transplant teams as a problem. Last year a survey of critical care units found that 3/5 of units do not have a full complement of critical care nurses, reducing the number of beds that can be made available.

Roberto Cacciola, NHSBT associate lead for organ retrieval and a transplant surgeon in London, told the ***Guardian***

"The UK has a lower donation rate compared to Spain, France and US. This means we have fewer organs available and fewer transplants"

How will the new law work?

Before the law comes into action there will be a major public awareness campaign. People will be told about the choices they can make and given the chance to register their wishes.

As an extra safeguard, family members will be asked if they were aware of any unregistered objection and donations will not proceed if it becomes clear that in an individual would not have consented

in Wales, the 'opt out' bill has been in place since 2015.

Life saver

Emily Ridgwell, who died aged six weeks, donated her heart valves, which saved the lives of two young girls, aged one month and seven months old.

Emily's parents, Amanda and Pete, asked staff at York Hospital and Martin House Children's Hospice - where Emily sadly died in 2015, about the prospect of donation.

Pete said: "Tissue donation was a beacon of light and as time goes on it gets nicer and nicer to think about. It meant a great deal to us that Emily was able to help a little girl with a similar birth date to Emily."

Register your details – Yes I want to donate

Rationing care – a slippery slope for the NHS

John Lister

Attempts to ration access to various treatments by NHS patients which have been made sporadically by local bodies since the 1990s are now becoming widespread and more wide-ranging.

The argument is that a significant number of hitherto routine treatments can be dismissed as "'Procedures of Limited Clinical Value', a term normally reserved for complementary therapies or cosmetic procedures where there is little evidence to prove their cost effectiveness or clinical benefit.

Last summer NHS England kicked off a new round of exclusions when it put pressure on local CCGs to cut funding for 17 procedures of allegedly limited effectiveness or clinical value – with an eye to making potential savings.

Four procedures for which there is a widely accepted lack of evidence (injections for non-specific low back pain without sciatica; knee arthroscopy for patients with osteoarthritis; dilatation and curettage for heavy menstrual bleeding in women; and surgery for snoring) were to be funded only in exceptional circumstances.

But a further 13 procedures, including breast reduction, varicose vein surgery, removal of benign skin lesions, and tonsillectomy – some of which have good evidence they can be effective, are to be performed on the NHS only when specific clinical criteria are met.

The NHS is aiming to more or less halve the number of these procedures, from 350,000 to 170,000 a year, and save almost half the current spend of £400m a year.

The list of treatments singled out for this has convinced many people that this as a further step towards introducing a two-tier system in which the better off are able to pay for non-NHS treatment, the poorer suffering in silence and private companies making a profit. Conspicuously as NHS bodies draw up longer lists of treatments they won't pay for, private hospitals begin advertising a similar range of services for those willing and able to pay.

NHS England gives the impression that the proposals are fully in line with national clinical guidelines published by the National Institute for Health and Care Excellence (NICE), the recognised authority advising clinicians on the current state of research evidence, whose logo appears on the cover, and that NICE was a source for the proposals.

But in fact, as Keep Our NHS Public has revealed, NHS England's proposals to withdraw 17 NHS clinical procedures *contradict* existing guidance from NICE.

Instead KONP research found that:

"For nine of the 17 procedures, NHSE does not cite any evidence at all from NICE. For five procedures the NICE evidence cited does not support the NHSE proposal and for one, the NICE evidence cited gives only partial support.

"For only two out of seventeen withdrawn procedures does the cited NICE evidence back the NHSE proposal."

However the initial list of 17 treatments was always seen as a first step, and some CCGs have gone far further and faster down the route of excluding services and effectively rationing care – leaving patients with the stark choice of going private or going without.

Bristol campaigners have been protesting over "Stolen Treatments" after the list of excluded treatments chiefs in the Bristol, North Somerset and South Gloucestershire (BNSSG) area reached a whopping 104. They complain that:

"GPs can no longer decide when to send patients to see a consultant at a hospital. Instead they must follow strict rules which mean they can only refer patients who are most severely affected.

"Some patients are being left with pain and disability and placed at increasing risk of severe complications. In addition, GPs' professional opinions are being overridden by non-accountable panels and committees."

CCGs corralled into line

In North Central London, the five CCGs have been corralled by the Joint Commissioning Committee into signing up for an extended list of 29 treatments, more than NHS England and the London Regional Directorate put together.

One of the North Central CCGs, Enfield, began its deliberations by discussing an even longer list of 192 procedures.

Keep Our NHS Public campaigners are angry that the changes once agreed by Enfield were rolled out "across the other four boroughs was done without public consultation. It is arguable that this is another breach of CCGs' statutory duty to consult the public before a significant change in services."

The same process is taking place in many CCGs across England. In Milton Keynes the CCG has a list of 26 MusculoSkeletal (MSK) treatments which are either "restricted" or "not routinely funded" with a much more lengthy list under "general".

Now research by the Medical Technology Group ("a coalition of patient groups, research charities and medical device manufacturers working to improve access to cost effective medical technologies for everyone who needs them") has found that rationing of care through these measures is increasingly widespread.

CCGs are restricting patient access to proven treatment by including them on lists of treatments of 'limited clinical value'.

This includes patients being denied vital cataract surgery; over half of all CCGs (104 of the 195 CCGs in England) include this procedure in lists of treatments they deem to be of "limited clinical value", despite being proven to be effective.

National clinical guidelines published NICE in 2017 cite the cost effectiveness of cataract surgery, stating that it has 'a high success rate in improving visual function, with low morbidity and mortality'.

The result of CCGs' restrictions on cataract surgery is that patients across the country are being denied access to a procedure that they are entitled to, which could restore their eyesight and prevent accidents, such as trips and falls.

The research also suggests patients are being treated differently depending on where they live. For example, Basildon and Brentwood CCG restricts access to cataract treatment while nearby Barking and Dagenham CCG offers the procedure to all patients.

The MTG's investigation, conducted in October 2018, reveals that CCGs across the country are also rationing access to other proven treatments which can make a significant difference to patients' quality of life and deliver savings to the NHS in the long run.

The MTG study looked at three further treatments: surgical repair of hernias, glucose monitoring for diabetes patients, and hip and knee replacements. It found that:

Most CCGs commission hernia repair, but many apply onerous conditions. Almost half of CCGs (95) limit access and many take a 'watchful waiting' approach, where time is allowed to pass while further tests are carried out.

The result can mean an increase in emergency cases and worse patient outcomes.

78 CCGs include hip and knee replacements on their list of restricted treatments, despite the procedures being proven to be effective in keeping people mobile.

12 CCGs refuse to provide patients with continuous glucose monitoring, a sensor that allows people with diabetes to monitor their glucose levels throughout the day. A further seven only provide it to patients after an Individual Funding Request, where they need to make a special case for the treatment.

Concerned that the treatment patients receive is being determined by where they live, not what they need, the MTG is launching Ration Watch, a campaign to highlight variation in local commissioning and call for changes to eradicate the postcode lottery.

Campaigners will want to use some of this research evidence, which is pressing for improvements in the NHS, even if they are not attracted to the MTG itself, which admits its membership "ranges from national charities to international companies."

Cataract surgery has "a high success rate in improving visual function, with low morbidity and mortality" – NICE guidelines

Liverpool appeal on charges for overseas patients

Bristol campaigners protesting against the same charges

Healthcare workers at Royal Liverpool University Hospital have published a statement in response to the introduction of ID checks and upfront charging in their workplace, and the devastating impacts of this policy they see every day. Medact has taken up the campaign on their behalf.

They are seeking support for the statement "to let the Trust know that it is our duty to advocate for our patients, to provide non-judgemental care, and ensure Trust policy improves care for our patients rather than causing harm."

"We believe that the policy conflicts with our duty towards patients, and, by turning clerical and clinical members of staff into an extension of the UK border force, undermines trust and distracts from our role as health care professionals.

"Furthermore, we believe the policy targets a vulnerable population, threatens public health, and is likely to lead to increased morbidity and mortality."

The group's mission is to campaign for healthcare charging of migrants to be suspended, and for Sections 38 and 39 of the Immigration Act (2014) to be repealed.

"We are calling on the Royal Liverpool University Hospital to make a public statement acknowledging the concerns of its staff and supporting the Royal Colleges' call to suspend charging, and to take immediate interim measures to reduce harm to vulnerable individuals."

Long journeys for Oxford gynae patients

From April 1 until June 30 women in Oxford needing gynaecology will have no local access to NHS services, according to statements posted online during March by Oxfordshire CCG.

Instead they face a minimum 26-mile trek to alternative NHS services as far afield as Frimley Park in Surrey (58 miles) Warwick (47 miles) or a laborious 40-mile journey with no viable public transport option to Milton Keynes.

And if they begin treatment at one of these far-flung alternatives, they will need to complete their treatment with the same provider.

The closest NHS option is Reading's Royal Berkshire Hospital 26 miles away. The CCG helpfully suggest a range of possible private hospitals – in Banbury (30 miles) Reading, Nettlebed (a rural area 19 miles away) or Buckinghamshire, which would no doubt be delighted to have more NHS-funded patients.

No explanation

The reason? Unexplained. The CCG simply warns the public that "Some women in Oxfordshire have been facing very long waits for certain gynaecology outpatient appointments and treatment at Oxford University Hospitals. We apologise for this."

A letter to GPs puts the responsibility on the Trust:

"Oxford University Hospitals NHS Foundation Trust (OUH) has capacity challenges in gynaecology. Every effort is being made by the Trust to improve this situation.

"Progress has been made in reducing the number of women waiting long periods for surgery but outpatient appointment waiting times are still a significant challenge.

"Women are experiencing waiting times for gynaecology outpatient appointments of 40-plus weeks. This is unacceptable in terms of care and patient experience."

The question is why neither the CCG nor the Trust has acted earlier to ensure that this core service remains available locally for women in pain.

The GP letter lists the problems for which no local service will be available for three months:

"OUH will not accept referrals for: pelvic pain; general gynaecology; urogynaecology; endometriosis; menopause clinics."

This is not the first time this problem has disrupted local provision of gynaecology in Oxford: just two years ago a similar warning to GPs was posted by the CCG:

"OCCG's main provider, Oxford United Hospital Foundation Trust (OUHFT), is currently struggling to find capacity within this service.

"Waiting lists are very long and this is causing a backlog, for various reasons, which they are now addressing urgently.

"… Many Gynaecology referrals to OUHFT are currently beyond the 18 weeks target, due to manpower and other capacity issues. Patients cannot be given an appointment when they book, leading to a lot of confusion and backlog, as well as extra work in primary care."

Questions need to be asked about the CCG's role in commissioning and monitoring the performance of the service and the priorities of trust managers at OUHFT.

Mental health leaders point to resource gaps and broken system

John Lister

Shocking new findings from NHS Providers' latest survey of frontline mental health trust leaders include the fact that fewer than 10% of trusts reported that they currently have the right staff in the right place to deliver services.

A massive 95% of people responding to the survey, which was conducted last November, do not believe overall investment will meet current and future demand. The most recent increases only raise the share of NHS funding spent on mental health by 0.5%; this rise is not adequate to close the care deficit: and too little of the new money that is available is reaching the front line of service delivery.

"This raises questions about how much of the NHS long term plan can be delivered and how fast."

More than two thirds of mental health leaders said they are worried about maintaining the quality of services over the next two years.

Community CAMHS services failing

An overwhelming majority (81%) of trust leaders said they are not able to meet current demand for community CAMHS and more than half (58%) said the same for adult community mental health services; more than half (56%) could not meet demand for crisis resolution teams.

In relation to overall community provision, 85% either disagreed or strongly disagreed with the statement that there are adequate mental health community services to meet local needs.

37% of trust leaders said they had to change or close services such as alcohol and substance misuse services, homelessness services and some inpatient services as a result of financial pressures, while more than half (55%) said they had changed or closed similar services or withdrawn mental health primary care provision due to commissioning issues.

A small number of trusts across the country felt that the amount of time people are waiting to access services such as psychiatric liaison, community CAMHS and inpatient CAMHS is decreasing.

However, far more trusts told NHS Providers that waiting times were increasing:

- 58% reported an increase in waiting times for community CAMHS and community adult mental health services
- 44% had seen an increase in waiting times for crisis resolution home treatment.
- And 41% increased waits to access inpatient adult mental health services

There have been large numbers of 'out of area placements' (OAPs) for lack of local capacity, with 70% reporting OAPs in acute inpatient treatment, 63% in CAMHS tier 4 patients and 58% for rehabilitation patients.

There is significant unmet need for a number of mental health conditions – particularly community services for adults and children, gender identity services and crisis home treatment teams.

Despite all of the government and NHS England rhetoric in the NHS Long Term Plan, and the Five year forward view for mental health before it on "parity of esteem" and improving resources, and a decade of campaigning to dismantle the stigma of mental ill health and achieve equity between the treatment of mental and physical health, NHS commissioning decisions are still resulting in services being cut or reduced.

Nearly two thirds of trust leaders are 'very concerned' about the numbers and skills of staff in two years time.

And an indication of the impact of austerity cuts on NHS services is the fact that too much current staff capacity is being diverted to support service users with a greater number of non-clinical issues "such as negotiating the benefits system".

"Demand for services is outstripping supply and socio-economic factors are contributing to this. 92% of trusts tell us that changes to universal credit and benefits are increasing demand for services, as are loneliness, homelessness and wider deprivation.

Cuts hit prevention

"Cuts to services funded by local authorities also mean that preventative approaches and early intervention services are less available. Mental health leaders pointed to rising demand during winter but it is clear that these pressures on services are a year-round phenomenon."

NHS Providers argues that to redress these issues:

"National policy must focus on increased support for both mental health and public health. There also needs to be greater realism about the levels of demand and what is needed to meet them, as well as better planning with inputs from trusts, commissioners and the national bodies."

Not surprisingly, action on workforce is identified as "a top priority", with calls for a national plan, with appropriate focus on the mental health workforce, coupled with "adequate funding from the comprehensive spending review that meets the plan's education and training budgetary requirements."

Of the external factors driving increased dependence on mental health services,

* 92% said changes to benefits/universal credit – with 63% saying the impact was high, making it the most significant factor
* 98% said financial hardship
* 97% said housing
* 97% said loneliness and isolation
* 91% said cuts to local services.

85% either disagreed or strongly disagreed with the statement that there are adequate mental health community services to meet local needs

Fewer than 10% of trusts reported that they currently have the right staff in the right place to deliver services.

Five day wait for mental health bed

A MENTAL health patient was left waiting in the Royal Blackburn Hospital's emergency department for almost five days for a bed, according to the East Lancashire Hospitals Trust's own documents.

The same document points to a year-on-year increase in the number of mental health 12-hour breaches, many more than in previous years.

There ave been 45 breaches of the 12-hour target waiting time at the A&E for mental health patients between January 1 and March 14 this year.

Lancashire Care Foundation Trust told the local ***Lancashire Telegraph*** that the patient would have remained in the A&E department and would have been supported by its mental health practitioners

The Trust argued that it needed more funding from commissioners to establish more provision in the community. Meanwhile they are paying for beds in a private mental health hospital:

"Until these additional services are fully operational we have commissioned an additional 22 beds from The Priory to manage the demand and we also use other capacity from within the private sector when appropriate, however these are not always available."

Hindered by Lansley's Act

The fragmented health care system entrenched by the 2012 Health and Social Care Act is clearly seen by many mental health leaders as an obstacle to progress. When asked what changes would most alleviate the pressures on services, trust leaders called for ending block contracts, but also:

- "delegating commissioning to providers" and
- "reducing tendering activity"

Other suggested changes were "investing in core services beds and community mental health teams, assertive outreach, crisis care, CAMHS"; "incentives to increase the workforce" and "capital for investment in estates".

Just over a third (36%) of trust leaders said they were satisfied or very satisfied with how mental health had been prioritised within their STP/ICS/ local system and 32% said they were neither satisfied nor dissatisfied.

Increasing pressure on services

Recent NHS statistics on mental health performance further illustrate the demand challenge for mental health trusts. In November 2018:

- The number of people in contact with NHS funded secondary mental health, learning disabilities and autism services **increased by 4.1%** to 1,310,985 (51,496 more people) compared to the average number of people contacting per month in the past year.
- Of these individuals, **78%** were in contact with adult mental health services, **17%** were in contact with children and young people's mental health services and **8%** were in contact with learning disability and autism mental health services.
- The number of new NHS funded secondary mental health, learning disabilities and autism services referrals **increased by 12.4%** to 320,349 (35,343 more people) compared to the average number of new referrals per month between in the past year.

Flaws in over-optimistic Cambridgeshire report

John Lister

The key findings from Stage One of an independent evaluation by York Consulting into the Primary Care Service for Mental Health (PRISM) have just been published by Cambridgeshire and Peterborough Partnership Foundation Trust.

It's clear that the report is to say the least limited in scope.

Out of more than 7,000 appointments by the PRISM team, the report includes data from feedback from just 16 of the patients in nine GP practices it gives no explanation of how these 16 were selected or how representative their views may be.

Perhaps their selection was related to the fact that

"all the patients were very positive about their experience of PRISM. Thirteen patients rated the quality of the service as 'excellent' and three as 'good'."

Despite such a small cohort of patients being asked how it worked for them, York Consulting make clear their enthusiasm for the PRISM project, claiming:

"Almost universally across those consulted for Stage One of the evaluation, there is strong support for the introduction of PRISM."

This "universal" support turns out to be mainly from the practitioners delivering the service:

"The ***vast majority of practitioners*** agree that there is a genuine need for the service and that it will improve the quality and responsiveness of mental health provision across the Cambridgeshire and Peterborough area."

However there was clearly much less universal delight amongst GPs – none of whom appear to have been asked their views:

"Feedback from practitioners on buy-in to PRISM amongst GPs was mixed, although on balance the positive feedback outweighs the negative".

In fact "just over half the practitioners" agreed that GP surgeries have been supportive of PRISM and that information about PRISM had been communicated effectively to those working in primary care.

One problem raised by a majority of the practitioners was clearly the lack of adequate staff to do the job required:

"more than half of those consulted felt that the size of their team was not appropriate for the scale of demand for PRISM, compared with one third who said there were no capacity issues."

Those practitioners who were less positive reported feeling detached from GP surgery teams and said that the high locum rate amongst GPs was having an impact on buy-in.

Later in the report it becomes clear that even PRISM practitioners feel that there is not an appropriate volume or range of treatment options for patients to be referred or signposted onto after their PRISM assessment.

They cite gaps in provision – especially of services for patients with personality disorders; long waiting times, especially around clinics for autism, psychological treatments and attention deficit hyperactivity disorder (ADHD); and geographic variations in access.

The report goes on to offer some fairly tenuous possible estimates of the cash saved through the PRISM project, although this is not linked with any details of how much the teams cost to provide the service.

In fact the Trust's own evaluation found PRISM cost more than identified costs savings, even ignoring the considerable cost of clinical supervision from secondary care.

Whatever the strengths may be of the PRISM project, such a limited and lop-sided review does little to inspire confidence in the robustness of its findings.

What the (research) papers say

Health Foundation reveals government's capital crimes

John Lister

While Matt "the App" Hancock waxes lyrical about the merits of new unproven digital solutions, the reality facing today's NHS is a desperate shortage of capital funding even to upgrade or replace crumbling buildings and clapped out equipment.

So says a shocking new report from the Health Foundation *Failing to capitalise*. In just 24 readable pages it paints the scale of the problem created by almost a decade of austerity-driven cuts and limits on capital spending since 2010.

It reveals that capital spending in NHS trusts has fallen 21% to £3.1bn between 2010/11 and 2017/18, and as a share of NHS spending it has fallen from 5% in 2010 to 4.2% in 2017/18.

The report pulls no punches, stressing the extent to which the NHS is now lagging behind the resources available in comparable countries:

"The UK now spends about ***half*** the share of GDP on capital in health care compared with similar countries, and is far behind other countries in the number of MRI and CT scanners per capita."

The situation is made worse by years of milking resources from already inadequate capital budgets to prop up even less adequate revenue and limit the size of trusts' deficits.

This is also what seems to have happened to most of the money raised from increasing sales of NHS land and property assets:

Sales of NHS capital have risen significantly since 2015/16, with over £400m in sales in 2017/18 (compared with £175m in 2010/11).

"While the government has committed to proceeds from sales being re-invested, this is not always the case, and in 2017/18 almost ***two-thirds*** of the proceeds from land sales went into the revenue, rather than capital, budget." (p12)

However capital to revenue transfers are not the only cause of the problem: "the UK would still have very low capital spending, by international standards, had these transfers not occurred."

In 2017/18 almost two-thirds of the proceeds from land sales went into the revenue, rather than capital, budget

As the capital budget has been spent on short term reduction of deficits, the maintenance backlog in NHS trusts has been rising, from £4.4bn in 2013/14 to over £6bn by 2017/18 (as reported in Lowdown #2).

The backlog, still growing, is around double the amount of annual capital spending in NHS trusts. Over £3bn of this backlog is 'high' and 'significant' risk, the two highest risk categories.

In 2017, the Naylor review estimated the backlog at just £5bn. The Health Foundation now warns that "investment in reducing the backlog needs to rise by approximately three-quarters just to stop it from growing further." (p19)

Without a change of direction on capital funding, the vision and ambition of Matt Hancock and NHS England for widespread use of "digital solutions" will inevitably fall flat:

"In 2018, the government announced a vision for digital, data and technology in health and care, with the goal of the UK leading the world in health technology. "

However NHS trusts have seen a 10% fall in inveswtment in plant and machinery since 2010/11.

"While IT has increased, it still makes up a very small proportion of the total value of NHS capital, at less than 5%.

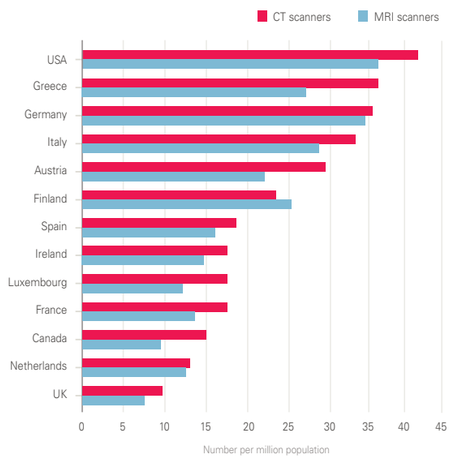
"It is unrealistic to expect the NHS to be a world leader in health technology when its capital spending on health care is much lower than in comparable countries, only a very small proportion of this is spent on IT, and spending on plant and machinery is declining." (p11)

There is qualitative evidence that trusts are unable to afford the most modern technology, such as scanners, while many are also using equipment past their estimated useful lives.

This can be deadly: low levels of diagnostic equipment threaten the ability of the NHS to improve care in line with commitments made in the NHS Long Term Plan (for example, new rapid diagnostic centres to improve early diagnosis of cancer) (p18).

NHS trusts have seen a 10% fall in investment in plant and machinery since 2010/11. "While IT has increased, it still makes up a very small proportion of the total value of NHS capital, at less than 5%"

Figure 3: CT and MRI scanners per million population, EU15 and G7 countries, 2016 or nearest years



Lifting the lid off privatised cleaning

Cheap – and Dirty!

The Thatcher government began the drive to contract out ancillary services in NHS hospitals in the mid 1980s, devising more and more ways to compel reluctant health authorities and hospital bosses to award contracts to private companies under cutting the cost of existing services, regardless of the impact on quality.

Campaigners fought back then and ever since arguing that privatised services would sacrifice standards in the pursuit of profit.

Academic studies in the early 2000s confirmed what many of us already knew.

But there has been relatively little focus on this until the publication recently of an important paper, Cheap and Dirty: The Effect of Contracting Out Cleaning on Efficiency and Effectiveness in Public Administration Review, the journal of the American Society for Public Administration. It is free to access.

It links contracting out to the fad for so-called "New Public Management" nostrums since the 1980s – and focuses on Britain, where it was implemented most energetically, and specifically the example of cleaning services in the English National Health Service

"By 2014, more than £100 billion of U.K. public services were being contracted out annually to the private sector.

"A number of high-profile cases have prompted a debate about the value for money that these contracts provide. Value for money comprises both the cost and the quality of the services."

Using data from 2010–11 to 2013–14 for 130 National Health Service trusts, the study finds that private providers are "cheaper but dirtier than their in-house counterparts."

The authors get it partly right when they argue that contracting out of public services, especially auxiliary services, "centres on the belief that it will lower costs and possibly increase quality."

However while the rhetoric mentioned quality, the Thatcher government which pioneered this privatisation process was preoccupied above all with price, and kept changing the rules to ensure contracts went to the lowest bid.

This has set the framework for subsequent contracting out. The study's authors argue:

"Economic theory predicts that when quality is hard to measure … suppliers may reduce quality to maintain their own costs, as they are the residual claimant on any profit."

As a result, they conclude: "Public service managers must be very careful when outsourcing services— even auxiliary services; some performance indicators should reflect aspects of the quality of the core service."

Indeed they go further and warn that the very process of tendering the contract can result in damaging patient care:

"We present and test a new hypothesis that contracting out of ancillary services may also lower the quality of patients health outcomes even when the core service remains under public provision."

They also bring a useful overview of the extent of privatisation of domestic services in the current period

"In 2010–11, a total of 39 percent of trusts were contracting out their cleaning services, while 59 percent used in-house teams. The remaining 2 percent had mixed modes of supply.

"The contracting-out rate increased to 41 percent in 2011–12 before falling to 37 percent in 2013–14."

The authors find evidence to prove a vital point:

"contracting out of health-care cleaning in the NHS from 2010–11 to 2013–14 was not associated with any quality improvement, after controlling for relevant health-care provider characteristics.

"On the contrary, this mode of supply resulted in lower cleaning standards as evaluated by patients and higher hospital-associated infection rates as indicated by MRSA rates."

With NHS England busily trying to persuade the public that they want to get rid of the legislation that requires services to be put out to competitive tender, it's worth remembering that trusts have continued to renew, retender and replicate the failings of privatisation 35 years after Thatcher first forced them into it.

It is a strong argument for bringing outsourced NHS services back in house.

Campaign sticker from 1984

"In 2010–11, a total of 39 percent of trusts were contracting out their cleaning services, while 59 percent used in-house"

Cleaners will call dispute if privatisation plans go ahead

Cleaners at Princess Alexandra Hospital in Harlow have put their bosses on notice that unless the hospital ditches "hazardous" plans to privatise cleaning services, they will go into dispute.

If a dispute is declared, the PAH Trust will have to come to the negotiating table to try to resolve problems.

If that fails external conciliation service ACAS will be brought in and if there's still no agreement hospital staff may be forced to vote on industrial action.

10 days to withdraw

UNISON has ***written*** to Trust chief executive officer Lance McCarthy, giving the board 10 days to withdraw from market testing – the first step in the outsourcing process – or face a dispute.

The union warns that there is "no rationale" for privatisation, saying workers are "deeply concerned about the ability of private companies to deliver these types of vital services within the NHS" given a history of private-sector failure.

More than 1,000 people signed a petition, calling on PAH to scrap the privatisation plans within a week. Harlow MP Robert Halfon (below) has told UNISON he is opposed to outsourcing at PAH, as has the local Labour Party.

Interserve still on the critical list

Paul Evans

Interserve, the giant government outsourcing contractor, which manages a host of crucial public services, was lifted out of administration by its creditors this week, leaving the NHS to calculate the possible impact.

Interserve has entered a 'pre-pack' package, under which it has been sold to the hedge funds and banks, that it owed vast sums of money.

This process meant the company's business could continue and has protected the jobs of its 45,000 employees in the UK for the time being. However, all Interserve's small shareholders, around 16,000, have lost their money.

Competitors are said to be circling in the hope of cherry picking parts of the business. ***The Guardian*** reports interest from Serco and Mitie

The implications to the NHS could be widespread. The company is perhaps best known for its facilities management contracts within the NHS, which cover a wide range of services that keep hospitals running smoothly, such as cleaning, catering and maintenance.

The GMB estimates Interserve had been awarded around £660 million in contracts while the company struggled with mounting debt

Subsidiary

However, its major subsidiary, Interserve Healthcare, is a leading provider of nursing and care staff to the NHS and social services. Its staff are contracted to work in nursing/care home facilities and to provide care packages for complex care in community-based settings.

Should the company go under, a large number of vulnerable people would be left having to find a new company to deliver care.

The company went into administration after its largest shareholder, the hedge fund Coltrane, refused to support a rescue package for the debt-laden company, but there were warnings about Interserve's precarious financial situation from late 2017, when the company gave a profits warning.

The company's first rescue deal to restructure its huge debt was in March 2018.

Despite its obvious financial difficulties, Government agencies continued to award the company contracts; in July 2018, two NHS contracts were awarded, a facilities management contract worth £35 million with Barking, Havering & Redbridge Hospital and a contract to extend and remodel the existing Neonatal Intensive Care Unit at Liverpool Women's NHS Foundation Trust worth £15m, plus there was a deal worth £66 million with the Foreign and Commonwealth Office for facilities management.

The Government knew about Interserve's problems and in early 2018, a report in the ***Financial Times*** spoke of a special government team being set up to monitor the financial viability of Interserve.

This was denied by the Cabinet Office, but ***The Mail on Sunday*** has claimed that ministers were so concerned that Interserve might collapse that plans were drawn up for the government to take over its contracts to enable hospitals to continue to function.

The presence of these contingency plans, according to the ***Mail*** article, shows that such is the reliance of government on outsourcing that some of these companies are considered too big to fail.

The GMB union told ***The Guardian*** that it estimates that Interserve had been awarded around £660 million in contracts during the past few months while the company struggled with mounting debt and going into administration was a possibility. In December 2018, Interserve announced that it needed another rescue package but in the same month was also awarded a £6 million government contract.

The run-up to the fall of Interserve has been likened to the collapse of Carillion, where the Government also continued to award the company contracts despite its well-known precarious financial position.

The collapse of Carillion in 2018 cost the taxpayer around £150 million, with more than 1,700 employees made redundant.

The company's collapse has led to delays to major hospital construction projects, however Carillion was far less embedded in the NHS than Interserve.

For a full profile of Interserve check out ***https://lowdwonnhs.info***

Hertfordshire & West Essex STP

Buildings crumbling, debts rising – and wishful thinking in place of plans

John Lister

With hospitals crumbling and in dire need of replacement in Watford and in Harlow, but trust deficits soaring, the arguments rumble on about the cost of any replacement and in the case of Watford, where the new main hospital for West Hertfordshire should be located.

The Sustainability and Transformation Plan for this rather awkward area comprising the whole of Hertfordshire with the bit of Essex that was seen as least viable, was almost the last one published in December 2016.

It is also the skimpiest of all 44 STPs, with just 32 pages, watermarked "Draft" throughout. Almost nothing was explained, and no details supplied, raising far more questions than answers.

Since then the only part of the STP to have visibly proceeded seems to be the employment of a Programme Management team, whose activity appears to be largely restricted to occasional publication of extremely vague newsletters.

Their few initiatives are small scale attempts to plug gaps or remedy deficiencies in existing services rather than bold innovations.

The main tangible proposals of the STP were for acute care to be cut back, with the implication that primary and community services and mental health might be expanded, although there have never been any details or commitments.

The proposed acute service reductions were very substantial: however the likelihood of achieving them was always open to doubt. The STP hoped to reduce admissions of frail patients by a very precise 11,231 [!] within 3 years and 24,451 in 5 years. They also wanted to cut admissions for Respiratory, CVD, Diabetes, Musculoskeletal and elective treatment, by a total of 16,000 in 3 years and 36,000 in 5 years.

The plans also look to cut hundreds of thousands of outpatient appointments (186,000 in 3 years and 456,000 in 5 yrs).

In fact in the two years of figures since the STP was published the numbers of patients aged 75 and over have increased by 4,000: emergency admissions have also increased, and the total of admissions has gone up by 7.5%.

The STP does not discuss the service implications of such large reductions in admissions and bed days for the acute trusts, but does commit to 'right size' the hospitals' overall bed base".

The STP does not discuss the service implications of such large reductions in admissions and bed days for the acute trusts, but does commit to 'right size' the hospitals' overall bed base"

The greatest pressure on beds is at Harlow's Princess Alexandra, a small hospital built in the 1960s for a much smaller caseload and which ended winter 2017/18 with bed occupancy above 99%, and just 67% of A&E attenders treated or discharged within the target 4 hours.

According to the STP West Essex could wind up with either a patched up Princess Alexandra Hospital – or the promise of closure and its replacement with a new £450m hospital on a "new" site, which may or may not be close to PAH.

A Commons adjournment debate on PAH on June 5 2018 brought news from Health Minister Stephen Barclay that the STP bid for £500-£600 million to develop a new hospital and health campus on a greenfield site to replace the old hospital had been sent back to the trust as "unsustainable."

It's clear that any future capital allocation towards the new hospital will fall far short of the amounts requested for a replacement on similar or larger scale.

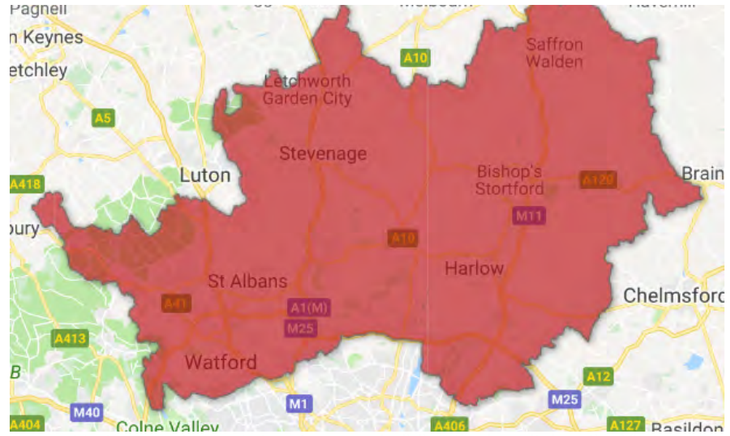
Meanwhile long-nurtured dreams of a massive redevelopment of a health campus to replace Watford General – for which the same STP apparently bid for another £600m of capital – were also brutally killed off.

Hopes dashed

With them perished the hopes of determined campaigners in Hemel Hempstead (which lost its A&E to Watford hospital 10 years ago) and other parts of the county for an alternative scheme: a new major hospital, in a more central and easily accessible location than the often congested and steeply angled Watford General site, which is right next door to the Vicarage Lane football ground.

Watford was selected as the main emergency hospital because at that time it was a very important 3-way marginal constituency: but it is the most inaccessible. It can take an hour or more by car from St Albans or Hemel Hempstead at 8am. By bus it is far worse – taking one and a half hours most times.

The West Herts Hospital Trust was in special measures for a number of years and the latest CQC report from late 2018 found it still needing improvement. It is £52 million in the red. The only new build at Watford to



cope with the 300 plus beds lost from Hemel was a temporary building for 120 patients – a glorified Portakabin-style structure which was said to have a life of 10 to 15 years and has had major problems since it was built.

Clearly they couldn't cope so some standard Portakabins, two floors, with Portaloos were put on the carpark. A recent '6 facet survey' obtained by campaigners through FoI reveals there is over £200m of maintenance needed.

In 2017 a Strategic Outline Case which estimated it would cost £1bn to build a new A&E hospital with 650 beds on a clear site bit the dust. In 2019 that figure has fallen to £750m – but this still seems very steep in comparison with other new-builds, and unlikely to be achieved.

Campaigners for an alternative site for a new hospital have published evidence to the CCG to show that building the hospital on the Vicarage Road site would cost at least £220m more, take far longer and pose more risks.

In June 2018 ministers also rejected the proposal for a new, more central hospital. Instead they rubber-stamped the down-sized Strategic Outline Case for rebuilding the crumbling Watford General, in a marathon project that will not complete until 2030 at the earliest

But then last December Chancellor Philip Hammond announced no more deals would be signed under the Private Finance Initiative, throwing fresh doubt on how much money can be raised for the rebuild.

NHS Improvement now says the Trust can only have what amounts to its turnover of £350m. On that basis they have dropped a new build hospital and are only looking at 25 to 40% new build at Watford.

Wild ideas in West Essex

Meanwhile in West Essex, the Princess Alexandra Hospital seems to be in pole position to be one of the first trusts to use a new form of private financing to help fund a replacement hospital.

Underinvestment means that the current condition of the estate is extremely fragile. A survey conducted in 2018 highlighted that 45% of the hospital's estate was rated as unacceptable or below for its quality and physical condition. Little investment has been possible since then.

The Trust is considering whether it can generate part of the funding for a new facility 3.5 miles away in east Harlow through a new "regional health infrastructure company" (RHIC). According to the ***HSJ***: "RHICs have been proposed by Community Health Partnerships, a government subsidiary, as a way of raising private capital for NHS infrastructure projects in a new form of public-private partnership. … However, the Treasury has not yet approved the model."

What details do exist suggest something very similar to PF2, the revised form of PFI in which public capital is used to keep down the cost of borrowing. PAHT has proposed a "blended" finance model to replace its main hospital in Harlow, to be financed through a mixture of land sales, capital funding from the government, and private income.

Unlike the Watford redevelopment, it seems certain that the new Princess Alexandra Hospital will be on a greenfield site: and the latest plan is for a substantial increase in size from the current 405 beds to 424 acute beds plus others – with a total of 633 beds and "care spaces".

This would make it almost the same size as the proposed Watford rebuild – but apparently at just 20% of the cost, £150m. Something here is wrong!

In other words this STP has carried on the way it began: with chronic deficits, crumbling hospitals, wishful thinking, overpaid management consultants and sums that just don't add up.

Labour Party invites us all to help solve the big challenges for the NHS

Paul Evans

Whether you're a member or not, the Labour Party want your views about how to turn the NHS around. This week they have launched a national conversation to collect views on the big questions facing our overburdened health care system.

Leafing through their consultation document you are immediately struck by the size of the questions being posed, some of which have vexed policy wonks and governments for decades.

Their list includes:

- How should we solve social care?
- How can we reorganise the NHS without disruption?
- How can we use technology?

Labour are giving respondents until 20 April. Enough time for the ***Lowdown*** to explore some of the answers,

So what's question number one?

What more can Labour do to ensure the NHS is fully funded and able to deliver universal health services?

On day one, a new Labour government will likely be confronted by an NHS still dominated by deficits. They will need to be prepared to give the NHS a financial jolt big enough to lift it out of short term crisis and into a new era of expansion, but how much will Labour need to spend?

The evidence from the IFS and other experts is clear. Changes in population, the cost of new treatments and the impact of technology, mean the NHS needs rises of at least 4% a year for the next 10 years.

Unlike the current government, Labour must take this advice, and crucially take action on social care too. Again, the advice is clear, social care needs annual rises of 4%, but also fundamental reform (which we'll explore in a future article)

Austerity has already robbed the NHS of the chance to properly plan for some of the major healthcare pressures; the crisis with obesity, the rise of chronic conditions like diabetes - which now costs the NHS 10% of its budget and the rising number of people living with health mental-health problems. These issues were all predicted, but the response was too weak.

So now the NHS has a much steeper hill to climb. New funding will have to be frontloaded to deal with some of the historic debt and an urgent list of 'must-do' investments that have been repeatedly put off.

Hospital buildings have been badly neglected. In his report for the government Robert Naylor thought that the service needs around £10 billion for new buildings and to address the backlog of upgrades and repairs needed on existing buildings.

Highest on the priority list for NHS leaders is the workforce crisis. The government has been desperately slow publishing its strategy, probably because the whole thing rests on extra funding. Labour must not make the same mistake.

The NHS has 100,000 vacancies some of which exist because staff no longer want to work under such pressure. By making the workforce a top priority Labour will not only rebuild services but send a message that the NHS values its staff

Prioritise the workforce crisis

Our NHS would be in a far worse condition were it not for the resilience of staff and their willingness to work unpaid beyond that hours – as 2/3 reportedly do. Although many are now leaving the NHS, due to poor morale, early retirement and Brexit.

There is a capacity gap across the NHS. The number of patients has been growing faster than the number of staff. In fact, the number of GPs is falling, as is the number of nurses and health visitors working in community and mental health services. This is at odds with new priority of treating many more patients outside of hospital.

To make this work Labour must invest in a new army of community staff; nurses, technicians and medics, especially in mental health.

The NHS has 100,000 vacancies some of which exist because staff no longer want to work under such pressure. By making the workforce a top priority Labour will not only rebuild services but send a message that the NHS values its staff. More will stay, others will join, some will return. A campaign is needed to attract them. It is going to need a serious strategy, worked out with the unions and it will take longer than their first five years in office to bear fruit.

The TUC outlines it in more detail, but here are five thoughts for starters.

- Reward staff with fair pay rises a good pension – it's a sign that their work is valued and will help retention
- Staffing numbers must reflect patient demand - apply safe staffing levels
- Make foreign staff welcome, offer grants to help – nurse recruitment has flat-lined since Brexit
- Invest in the wider well-being and career development of staff - help provide affordable homes near workplaces
- NHS leaders must set out a compassionate culture, no bullying and promote quality, diversity and inclusion

One more thought. Ending privatisation will stop NHS staff being forcibly transferred to new employers and protect pay and conditions. Better still bring staff back in house. Where it has been tried, most noteably in Wales, it has boosted moral and improved the quality of services.

Restore an accountable NHS

Next Labour must put in place some accountable structures that allow for the proper planning of healthcare. It starts at the top by restoring the responsibility of Health Secretary to provide care to all

We all agree we want to save it: but how do we set about it?

of us, which was removed by the Health and Social Care Act 2012. Simple to rectify, but highly significant.

After u-turning on their experiment with competition the government is advancing plans to integrate services, but they can't restructure because they lack the muscle to push new legislation through Parliament.

The government is busy bending the existing structure to pull together their new local partnerships (integrated Care Systems). Their governance looks rickety and whatever a Labour government inherits will have to be cleaned up with primary legislation, but not necessarily replaced.

NHS England are installing regional directorates to enforce national policy, but they are not accountable. Local bodies (CCGs and Health and Well Being Boards) are all merging to for make larger areas for planning purposes, but these look too big to act locally and too remote from local people.

The NHS needs more local accountability as the public are losing touch and influence. Who is in charge? How are decisions made? Where is the public voice?

This is not just about a safety valve against bad policy, it's a way of putting public interests at the heart of decision making. Of course, accountability does offer protection, making it harder to ignore areas of neglect and difficult to force through plans that the public and NHS staff disagree with.

At a recent meeting on the Policy Review, my colleague at the ***Lowdown***, John Lister sketched how this could work.

"In my opinion we should have the equivalent of one health board per county or unitary authority (giving around 150), and for simplicity the health districts should mostly be coterminous with local government.

"These boards must be public bodies, meet in public, publish board papers, and include elected councillors, lay members and trade union reps (as did Health Authorities prior to 1991).

"This too will be welcomed by most people who care about the NHS. It is taking forward and seeking to democratise a process by which NHS England has already begun to bypass and neutralise the provisions of the 2012 Act."

Hold on to the principles of the NHS

Make it fairer, Health inequalities have grown. The Kings fund noted that "Recent data published by the ONS indicates that, for those living in Herefordshire, the average disability-free life expectancy is 71 years. However, if you live in Tower Hamlets in East London, your disability-free life expectancy is 55 years."

In 1997 Labour formed a Royal Commission to look at ways to fund long-term care. It proposed that Labour make both healthcare and personal care free at the point of use. The Blair government ignored these findings

And yet there is a startling false economy at the heart of this issue. Researchers at the University of York tell us that socioeconomic inequality costs the NHS in England £4.8 billion a year, almost a fifth of the total NHS hospital budget.

We must redirect resources, not only to eliminate postcode lotteries and respond to unfair differences in access to care, but also to look at ways to keep people well and prevent sickness.

Public health budgets have been cut year on year. Many reports have been issued by successive governments, but few stick with it. partly because the rewards will not be reaped for decades. but in an era of integration this is an opportunity for Labour to link policies on health, housing, the environment and welfare.

Some communities like Morecambe Bay are already finding answers for themselves by starting to talk about it, and it is having results. Perhaps it is time to involve communities in the solutions and bring the debate out of dusty reports.

Keep the service comprehensive.

In 1997 Labour formed a Royal Commission to look at ways to fund long-term care. It recommended that Labour make both healthcare and personal care free at the point of use. The Blair government ignored these recommendations. Meanwhile, in Scotland they forged ahead and personal care, such as feeding, bandaging and giving of medicines, was made free in the way it is that it is in NHS hospitals.

Labour must rectify this mistake. It is more pressing now because the line between healthcare and social care is becoming more blurred as we transfer treatment outside of hospitals into the community. Who will pay? What is free? The danger is clear as charging and top up fees are already well established in social care.

Underfunding has revved up rationing in the NHS. Eligibility criteria tightens more each year. Patients have to be sicker to qualify for the treatment they need. Or wait longer, and some treatments drop off the list altogether, but not for always for clear clinical reasons as we saw with proposed restrictions on hernia and cataracts.

Dentistry, long term care, personal care, podiatry, physiotherapy, talking therapies are all area where NHS provision has shrunk and if we can afford it, we put our own hands in our own pockets and organise our own care. This can't go on unwatched, all governments should be committed to keeping the NHS comprehensive in reality, not just repeating their support for it at elections.

THE lowdown

Health news, analysis and campaigns.
NUMBER 1, April 27 2019

Informing, alerting and empowering NHS staff and campaigners

Failed private Sussex provider still owes £11m

Coperforma, the privately-run patient transport provider still owes £11m to the NHS and its other suppliers years after its contract was withdrawn as a result of a catalogue of problems.

It was one of the most controversial failures in recent times.In 2016 Coperforma were awarded a contract in Sussex for non-emergency transport - a four-year deal worth £63.5 million with seven CCGs, replacng the NHS's South-East Coast ambulance service.

The contract was withdrawn after a matter of weeks due to shocking failures in the service. Within days problems with the contract hit headlines in the local and national press. Crews were failing to pick up patients, leading to missed appointments and patients languishing for hours in hospitals awaiting transport home.

Patients included those needing kidney dialysis and cancer patients attending chemotherapy sessions. The GMB union representing the ambulance crews said it was an "absolute shambles".

Finally, in October 2016, Coperforma were forced to give up the contract. But even now according to a report in the ***Health Service Journal*** local NHS commissioners are still trying to recover £7.6m.

Campaigners play key role in defeating North West London closure plan

Campaigners in North West London who have battled long and hard since 2012 to defend Charing Cross and Ealing Hospitals were quite rightly celebrating in the aftermath of the decision by Matt Hancock to scrap the widely hated Shaping a Healthier Future (SaHF) project (see inside pages 4-5).

Without their tenacity – and constant reference to hard evidence and a detailed critique of the plan as it evolved from a hospital merger plan to a wholesale downsizing of services covering 8 London boroughs from nine acute hospitals to just five – NHS chiefs might have succeeded in forcing through their deeply flawed plan.

Campaigners' pressure helped ensure continued resistance from Ealing council and a Labour group in Hammersmith & Fulham that fought and won leadership of what had been a flagship Tory council on a platform of fighting to save local hospital services.

Hammersmith council then took the lead in establishing the Commission led by Michael Mansfield QC which called in December 2015 for the SaHF scheme to be scrapped, and in joining with Ealing council to stand firm in rejection of the Sustainability & Transformation Plan in 2016 which also tried to push through the closures of Charing Cross and Ealing hospitals.

The delay to the plan ensured that the real, soaring costs of implementing it were revealed, and the deeply flawed assumptions of reduced demand on acute and A&E services were exposed, resulting the hospital trusts resisting SaHF's proposed massive cuts in bed numbers.

In other words the campaigners created conditions for the plan to effectively collapse through its own weaknesses: in similar fashion we can now see plans for controversial cuts in bed numbers drawn up in various STPs in 2016 being surreptitiously dropped as unworkable.

Had there been no resistance, these schemes might have been pushed through – with disastrous consequences.

● ***The Lowdown*** will continue to chart the evolution of STPs: see our analysis of Nottinghamshire pages 8-9.

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

IN THIS ISSUE

Could this really be the end of hospital waiting?

By Paul Evans

Visiting your local hospital could be a far rarer event as NHS England plan healthcare much closer to home. However, turning this vision into reality hangs on NHS leaders overcoming a big crisis in staffing.

Traditionally the next step on from your GP is the local hospital, whether it is to help diagnose or to start treatment. But NHS England has concluded that many of these trips are unnecessary and clog up an already over whelmed hospital service.

NHS leaders are working on plans to treat more of us in community settings. Instead of going to your local hospital for tests, treatment or check-ups you will be sent to a community-based facility, part of a Primary Care Network which will house multi-disciplinary teams of health professionals.

Jargon aside, this means GPs, community nurses, therapists and technicians all working together from large, souped-up health centres connected with other core services like social care. At least that's the vision, but can it be delivered?

Challenge

The size of the challenge is significant. It means a huge investment in extra buildings, community staff and technology. The government have pledged an extra £4.5bn for primary care over the next five years, but health economists are already agreed that this is not enough and will mean some tough choices.

NHS leaders have set a dizzying target to reduce the number of outpatient appointments by 30 million a year, a goal they explain in their 10-year plan for the NHS published earlier in the year.

Our hospitals contend with very high demand, outpatient care has been rising at around 3% a year and this new policy aims to put a brake on this by rerouting an army of patients towards community facilities. However, as yet these services don't exist in anything like the scale they need to.

Who will treat take on this extra work? General practitioners will lead the community teams, but they are wincing at the prospect. The number of GPs has actually fallen over the last five years.

There are now 1784 fewer GPs than there were in 2013 (full time equivalent) according to figures published by NHS Digital.

NHS leaders have set a dizzying target to reduce the number of outpatient appoint-ments by 30 million a year

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The health secretary promised 5000 more by 2020. After missing their recruitment target for two years more young GPs are finally joining, but most areas are still understaffed, particularly as older GPs are retiring at twice the rate that they were in 2010.

All this explains why many of us are finding it hard to get a GP appointment. One in five patients now has to wait at least 15 days to see a GP in England, NHS figures have revealed. Meanwhile our need for healthcare has grown, the number of GP patients has risen by 16% in the last 7 years.

Capacity gap

There is a yawning capacity gap, which has widened throughout the recent years of austerity. The problem for NHS leaders is that community services are already struggling, but the gap must be bridged if they are to have any hope of redirecting thousands of hospital patients towards community services.

Health visitors have seen their numbers fall by nearly 10% in the last five years. Many are dealing with perilously high caseloads to manage. A recent study found that some health visitors are responsible for up to 830 children – when the recognised safe limit is 250.

Staff are running the risk of being too busy to spot domestic violence or child abuse or to have too little time to catch the signs of a mother with postnatal depression.

The same pressures are evident for district nurses, who also know that their patients are getting a worse service.

"When you have a big list of patients to see in the day, if you want to get through that list, you really need to rush… you end up going and doing whatever you're there to do, but fail, sometimes, to notice that that person is actually not herself today, or something's wrong. The workload is the main enemy for the patient centred care."

Shockingly district nurse numbers have fallen by 46% since 2010, although part of this can be accounted to the transfer of staff to other providers.

Private providers like Virgin have won large contracts to provide a wide range of community health services to the NHS in Somerset, Devon and Essex and often NHS staff have transferred to work for these providers. It is unclear how this part of the market will develop, although the NHS will be in a much stronger position if it expands its own community staffing.

"The targets in the Long Term Plan don't feel particularly realistic at the moment because of the absence of any clarity about investment"

Whilst there is apprehension about the new plans, other NHS staff are more positive, as to some they about promise more cohesion and a more appropriate community-based model. There is no doubt that NHS England's vision has been powerfully painted, but even so there are worries about what is achievable.

Helen Stokes Lampard, a GP and Chair of the Royal College of GPs is supportive of the aims but has yet to see a difference on the ground

"There are workforce shortages right across the board. In the first year, the only additional employees PCNs (Primary Care Networks) are looking to take on is more pharmacists and social prescribers." (source: NHS Providers website)

Siobhan Melia - Chief Executive of Sussex Community NHS Foundation Trust commented,

"The targets in the Long Term Plan don't feel particularly realistic at the moment because of the absence of any clarity about investment"

When will the extra staff arrive and how?

The government avoided this crucial question when it published the Long Term Plan in January. Commentators noticed the hole in the plan immediately. A workforce plan would follow later the government reassured us. But getting the right level of staffing is fundamental.

One of the reasons for the delay is the extra cost that it will entail. The issue is now caught up in the wider Autumn spending review.

All government departments are vying for extra cash and the NHS is seen to have already done relatively well by avoiding outright cuts that have hit many other public services.

However, the reality is that the £20.5bn already announced is not enough to fuel improvement, economists agree on this.

So why leave the job half done? The NHS needs the investment to support a new plan to expand the NHS workforce, the whole plan hangs on it and without it the vision of community-based healthcare lacks credibility.

NHS hospitals still privatising staff with spin-off companies

The successful strikes at Wrightington Wigan and Leigh have blaized a trail

Bradford Hospital Trust is seeking to offload much of its non-clinical work to a wholly-owned subsidiary, including all its estates, facilities and clinical engineering services.

Judith Cummins, Bradford South MP, however has condemned the move by the trust saying it will worsen employment rights and make it "much easier to privatise the running of essential services."

Ms Cummins has written to Matt Hancock, Secretary of State for Health and Social Care, and the CEO of NHSI in an effort to reverse the trust's decision.

The trust says it is carrying out a full programme of consultation with staff.

In contrast, in early April Rotherham NHS Foundation Trust shelved its plans for a subsidiary following widespread opposition from unions, staff and the local MP John Healey. The trust had employed management consultants Grant Thornton to support setting up the subsidiary.

● What are spin-off companies in the NHS?

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The formation of these subsidiary companies is widely viewed as a back-door form of privatisation, which could lead to a worsening of employee rights and the creation of a two-tier workforce.

In 2018, a backlash against their formation led to NHS Improvement issuing new guidance. Plans for the subsidiaries now have to be scrutinised and approved by NHSI; Bradford Hospital Trust says that the NHSI has agreed its plans and given it the go ahead.

The £9.9 million KFM used to buy the equipment was obtained via a loan from King's College Hospital Trust itself.

Hospital trusts have been enthusiastic about this approach as a way to save money and reduce deficits.

There are two ways money can be saved: through the VAT system - a private company working for the NHS is covered by different tax rules and can claim back any VAT it is charged from the Government; and, by changing the pay and conditions of staff - the companies will not be obliged to employ new staff on NHS pay and conditions but will instead be able to offer very much worse terms of employment.

A recent article in the HSJ, on King's College Hospital Trust and its subsidiary KFM, however, reveals just how complicated and even absurd the whole situation can become between a trust and its subsidiary.

It throws into question of whether this approach is a valid response to reduce a deficit.

In 2017/2018 King's College Hospital Trust had one of the largest deficits reported of £132 million and in 2018/2019 it is expected to rise to £146 million. In 2016 it set up the wholly-owned subsidiary company KFM and transferred around 60 employees.

Details from King's College Hospital Trust accounts for 2017/2018 reveal that it recorded nearly £10 million in income from KFM.

The income was from the sale of equipment to KFM, including scanners, however the £9.9 million KFM used to buy the equipment was obtained via a loan from King's College Hospital Trust, itself.

KFM only has contracts with the trust and charges the trust £97 million a year for these services. KFM also charges the trust for use of the equipment that it has just bought off the trust.

Furthermore, KFM is financially dependent on the trust, with King's College Hospital Trust having agreed to a "revolving loan facility" with KFM of £30 million.

This is due to be repaid in full in March 2027 and interest is paid at the Bank of England base rate plus 2%.

The KFM/King's College Hospital trust situation also highlights issues around accountability and conflict of interest with the subsidiary companies; until recently several board members of KFM were also finance directors of the trust.

Yorkshire stroke units to close as national reorganisation continues

Two of five stroke units are set for definite closure in the South Yorkshire and Bassetlaw integrated care system, according to an article on Health Services Journal.

The closure will be staggered, with the Rotherham Foundation Trust losing its hyper-acute stroke care department first in July this year, followed in October by the closure of the department at the Barnsley Hospital Foundation Trust.

Hyper-acute stroke care is the very specialist care given within the first 72 hours after a stroke.

● NHS plan falls short on national staffing crisis
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Patients who would have gone to Rotherham will now be taken to either Royal Hallamshire Hospital, Sheffield, or Doncaster Royal Infirmary, depending on which is closest.

Those who would have gone to Barnsley will go to either Doncaster Royal Infirmary or Pinderfields Hospital in Wakefield.

Acute stroke care and rehabilitation services will still be provided at all the hospitals within the ICS, with patients moving out of hyper-acute stroke care back to other hospitals as soon as possible.

The closure of these two units was the subject of a legal challenge launched by a Barnsley resident, along with Save Our NHS groups in Barnsley and Rotherham.

In July 2018 a judge refused permission for a judicial review of the closures. The decision for the closures was made in November 2017 by the Joint Committee of the Clinical Commissioning Groups.

Stroke units have been a major target in reorganisation plans within sustainability and transformation plans written back in 2016 and now are part of plans for integrated care systems (ICS).

Kent and Medway

In February 2019, the joint committee of clinical commissioning groups (CCGs) in Kent and Medway approved plans to replace six stroke units with three hyper-acute stroke units based in hospitals in Dartford, Ashford and Maidstone.

Kent campaigners and local councillors have raised concerns about the calculations used to justify the changes, saying that the impact of longer journey times to hospitals have not been properly considered and compiled using data from London where distances are shorter.

There were also concerns about the capacity of the new system as the plan involves a permanent 16 per cent reduction in bed numbers for stroke patients, from 154 at present to 129.

■ As we reported in March (Pilot Issue #3) Medway Council has confirmed that it will seek a judicial review of the decision.

Lessons must be learned from axed North West London project

John Lister

At the end of March Health Secretary Matt Hancock finally axed the long drawn-out and shambolic project to reconfigure hospital services in North West London. He told MPs that the plan which was once held up as a model for others to follow is no longer supported by the Department of Health and Social Care, by NHS Improvement, or NHS England.

But it's not only ministers who are now distancing themselves from this failed project. Since Hancock's statement many key players, including senior figures from NHS England's shadowy London Regional office, some of whom have since reinvented themselves as management consultants, will have been praying the embarrassing details will be swiftly forgotten or buried. There is a lot for them to keep under wraps.

Soaring cost

While the headline cost of the whole scheme rocketed from £190m to over £1 billion, project costs for the hugely expensive 'Shaping a Healthier Future' (SaHF) scheme frittered away more than the cost of a substantial-sized new hospital, but delivered nothing but a stack of flawed and incomplete documents.

These included one of the largest-ever preliminary documents in the NHS (2,700 largely unread pages in 7 giant volumes of the "Decision Making Business Case" published online in 2013, a download totalling 86 megabytes).

By the end of 2017, when SaHF stopped publishing information on the costs of management consultants, local experts had already totted up official figures revealing a staggering total of £72,285,181 squandered in five years on management consultants.

However consultancy fees were only a minor component of spending on the SaHF project over the whole 7 years of the project: advisors to the Commission led by Michael Mansfield QC which investigated the plans in 2015 used actual figures from NHS reports, coupled with informed estimates, to estimate that the total costs by 2017/18 would be a massive £235m.

SaHF project leaders claimed they "did not recognise" the figures – but have never published any alternative figures to show how much has been spent. In June 2016 they revealed that a small army of 130 people, including 75 "interim executives" were employed on the project, and that more than a hundred of these would still be in post by March 2017.

Despite these lavish resources, and multiple contracts for management consultants to complete a final business case, the project which began in 2012 had not done so 7 years later.

So poor was the plan that it had its application for capital funding rejected twice by NHS England and NHS Improvement citing the very problem highlighted by campaigners – a lack of detail on how care was going to be reprovided.

By the end of 2017 local experts had already totted up official figures revealing a staggering total of £72 million squandered in five years on management consultants.

Nor did the services of consultants including McKinsey, Ernst & Young, PwC and Deloitte prevent the adoption of deeply flawed proposals. The closure of A&E services at Central Middlesex and Hammersmith hospitals in the autumn of 2014, triggered a disastrous – but entirely predictable – plunge in A&E performance standards.

It later emerged that (as critics of the plan had warned) the project leaders had made significant errors in calculating the numbers of beds required.

Only now, almost five years later and after extra beds have been opened has performance in London North West Hospitals begun to move back towards the level it was at before the closures (see graph below).

The SaHF project never won any public acceptance in the boroughs it most affected: in fact it was instrumental in the Conservatives losing control of one of their flagship London boroughs, when a Labour campaign won Hammersmith & Fulham council, pledged to fight to save Charing Cross and Ealing Hospitals.

The determination of this council to halt plans to downgrade and close local services, coupled with sustained and vigorous activity by local campaigns working together in both Hammersmith & Fulham and Ealing played a major role in delaying the process and allowing reason to prevail.

Even local trust bosses began to distance themselves from planned cuts in bed numbers.

Indeed few people who were not paid to do so ever shared SaHF's ambition to close acute services and demolish the main buildings at Charing Cross and Ealing Hospitals, and sell off most of their sites to developers, building minimal new "hospital" facilities on small residual plots.

Few people believed the heroic assumption that as yet unbuilt "community" and out of hospital services would result in drastic reductions of patients requiring emergency hospital care (99,000 fewer by 2025) and allow a net reduction of 364 beds in "outer NW London" and further cuts adding up to 500 beds overall.

However the damage done especially to Ealing Hospital by the SaHF plan lingers on. Its services were fragmented and downgraded with the loss of maternity and paediatric services, and the looming threat of impending closure of more services and restricted scope for training doctors made recruitment and retention of medical and nursing staff more difficult.

Campaigners are also pressing for the Public Accounts Committee or National Audit Office to mount a rigorous external inquiry into how so much time and money was wasted

No plans to repair damage

As yet no plans have been published to reverse or repair any of this.

The problems also extend to Charing Cross and St Mary's hospitals, part of the Imperial Healthcare Trust, which as ***The Lowdown*** reported in February has the largest backlog maintenance bill in the country, adding up to a massive £649m.

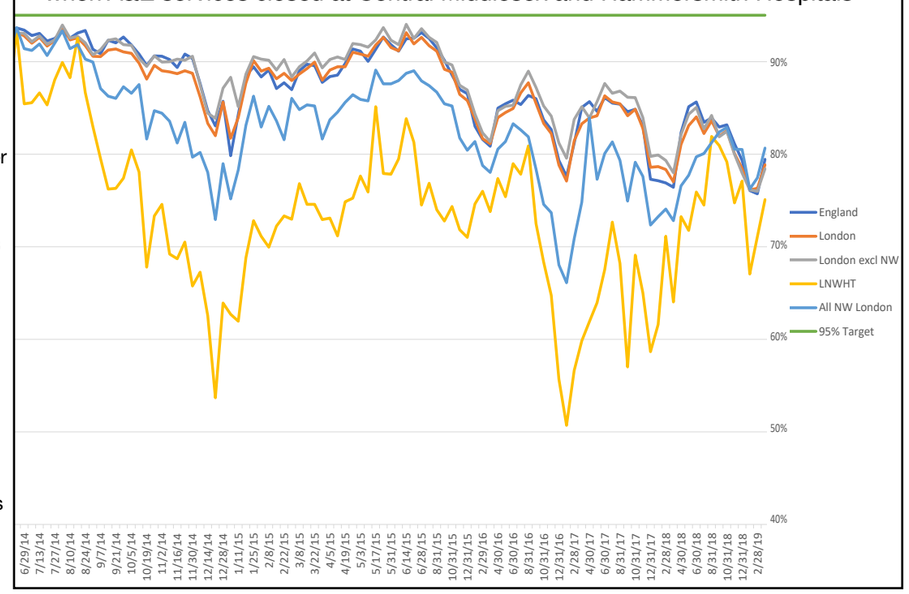
Scrapping the plans to asset strip Charing Cross to raise capital to rebuild the crumbling St Mary's, which in some cases is actually falling down, leaves the urgent question of how urgent repairs and upgrades are to be paid for while the austerity regime prevails in the NHS.

Now the plan has been scrapped and the arguments largely discredited, campaigners are also pressing for the Public Accounts Committee or National Audit Office to mount a rigorous external inquiry into how so much time and money was wasted by so many. Hopefully this will deter any NHS managers who may have looked to NW London as a model from following down the same dead end.

Some of those responsible have since scuttled off to become chief executives or management consultants rolling out similar nonsense elsewhere – and also need to be called to account.

Those who cannot learn from the errors of the past are doomed to repeat them, and any attempt to use the SaHF fiasco as a learning exercise requires a rigorous critique of why it went so wrong and wasted so much money at a time of great financial hardship for the NHS.

Still not recovered – the collapse in London North West Hospitals performance on the most serious Type 1 A&E within 4 hours, from autumn 2014 when A&E services closed at Central Middlesex and Hammersmith Hospitals



Dangerous lack of nurses affects a one in four hospital wards

By Sylvia Davidson

One in four wards in acute hospitals across England are dangerously understaffed, according to a study by researchers at the University of Southampton and Bangor University.

The study, entitled Implementation, Impact and Costs of Policies for Safe Staffing in Acute NHS Trusts, questioned 91 nursing directors, and analysed national workforce data and four case studies at NHS trusts.

Hospitals were found to be experiencing major difficulties recruiting and retaining registered nurses; the average registered nurse vacancy rate was 10% across the country, but up to 20% in some trusts.

On top of this issue, the study found that despite Government workforce data showing that the number of nursing staff has increased since 2013, an increase in patient admissions means that there has been no net improvement in registered nurse staffing levels.

Nursing support staff (e.g., healthcare assistants), however, have increased at three times the rate of RNs since 2013, and the researchers note that this results in a "dilution of skill levels in NHS acute care."

Francis Report "forgotten"?

The researchers note that the lessons from the Francis enquiry reported in 2013 into the scandal of patient deaths at the Mid Staffordshire Hospital Trust - to put patients first and never let it happen again - have "become more muted."

The RCN responded to the reports by noting that "lessons from the Francis Report are being forgotten, despite this being a once-in-a-generation opportunity to increase nurse staffing levels across all health and care settings."

This is not the first study to conclude that dilution of skills is a major issue for patient safety. Replacing RNs with lower skilled nursing assistants for health care assistants was found to be linked to a heightened risk of patient death, as well as other indicators of poor quality care, according to a 2016 study published by the journal BMJ Quality & Safety.

The study found that for every 25 patients, just one professional nurse substitution was associated with a 21% rise in the odds of dying in a hospital with average nurse staffing levels and skill mix. The researchers concluded that "diluting" the hospital nurse skill mix "is not in the public interest."

Other studies support the observation that low nurse staffing levels are associated with adverse outcomes and have shown that HCAs cannot make up for deficits in patient safety due to a shortage of registered nurses.

The government's own research institute, the National Institute for Health Research (NIHR), which is funded by the Department of Health and Social Care, agrees that the number of registered nurses is key to safety. In March 2019, it published the review Staffing on Wards, which analysed 20 separate nursing and staff-related studies that had been funded by the NIHR, and concluded that it is the number of registered nurse hours at the bedside that avoids patient harms.

For every 25 patients, just one professional nurse substitution was associated with a 21% rise in the odds of dying in a hospital with average nurse staffing levels and skill mix

● NHS plan falls short on national staffing crisis

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Back in 2013, recommendations from the Francis report stated that the ratio between staff and patient was of fundamental importance to safety and quality of care.

The National Institute for Clinical Excellence (NICE) produced guidance on patient-to-staff ratios for acute wards, with a 1:8 nurse-to-patient ratio after research showed that this is the level at which harm starts to occur to patients. Safe staffing data dropped

In order to increase transparency on issues such as nursing levels and improve safety, the Francis enquiry also put in place the publication of data on actual nurse staffing levels versus planned levels of staffing for each hospital trust. However, on the same day that the University of Southampton study was released, HSJ journalists reported that this measure had been "quietly dropped." The data could be used easily as a way of keeping track of how a hospital was performing.

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In the past the data has been used to show that hospitals were failing to meet their targets for nursing levels; in 2015 HSJ reported that more than nine out of 10 acute hospitals were failing to meet their targeted numbers and in 2017 the RCN used data released on the NHS Choices website to show that 45 of the 50 largest trusts in England were not staffed with nurses to the planned level.

The data was updated each month on the NHS Choices website. It showed the percentage of nurse shifts filled versus the level planned for that hospital also known as the average staffing fill rate. An important aspect of the data was that RNs and care assistants were recorded separately as studies point to the number of nurses being the key to patient safety.

New approach

Now, staff data is still being published on the NHS Choices and the MyNHS website, but using a new approach, the care hours per day (CHPD) metric; this measure combines registered nursing and unregistered care assistant shifts.

It is therefore no longer possible to find out how the care hours provided by nurses compare with the level the trust, hospital or department had been planning for, and either exceeded or fell short of – an indication of safety.

The CHPD was put forward by the Lord Carter, the NHSI non-executive director, in his 2016 review, however it has been widely criticised. The measure does not take into account the different skills within the workforce.

A major criticism is that its use could lead hospitals to employ more healthcare assistants to increase their average care hours, at the expense of registered nurses.

Based on the current trajectory there will be 250,000 vacancies within a decade if no determined action is taken to change things

Overwhelming evidence

The University of Southampton study is one of a series of studies, reviews and reports that have been published in recent years that all highlight the growing workforce issues in the NHS. There are now around 100,000 vacancies in the NHS, with many of these positions having to be filled by agency workers and bank staff at great expense to the NHS.

A report by the think-tanks, The King's Fund, The Nuffield Trust and The Health Foundation published in March 2019, predicts that based on the current trajectory there will be 250,000 vacancies within a decade if no determined action is taken to change things, including an extra £900 million per year by 2023/24 into the budget of Health Education England.

Despite the evident crisis in the workforce, the ten-year plan for the NHS, published by the Department of Health and Social Care in January 2019, did not include a workforce plan.

An interim workforce plan was expected to be published in April 2019, however this plan will not set out how the new staff role will be funded, this will take place in the autumn spending review.

Speaking to HSJ at the end of March, Julian Hartley, the national executive lead on the workforce plan, said that the plan would not say "things about priorities and investments" but "would instead set out a direction of travel for workforce policy."

Fightback as contractors' staff demand NHS pay

Catering staff at Doncaster and Bassetlaw NHS Foundation Trust are the latest to vote for strike action in a growing wave of strikes by privatised contract staff working in NHS trusts.

The Doncaster and Bassetlaw staff were transferred to private company Sodexo in January 2017 – and the company is refusing to pay them more, arguing that the government has chosen not to allocate the extra funding for contractors that it has given to NHS trusts to meet the costs of last year's increase to the Agenda for Change pay scales.

UNISON argues that the trust governors were assured catering workers would remain on NHS pay scales when they took the decision to privatise the service, and that the company has now gone back on its assurances.

Sodexo cheekily told the BBC it supports "Unison's position in lobbying the government for central funding and, if successful, we guarantee to pass that funding on to our employees".

On April 15 hundreds of members of unions GMB, Unison and Unite staged a lunchtime protest to express their anger at the shoddy treatment they have received from ISS, which employs around 600 staff across the Royal Liverpool Hospital, Broadgreen hospital and The Walton Centre in Aintree.

Cleaners, catering staff and porters, all on near the minimum wage, were facing a week without pay after ISS decided to 'upgrade' its pay roll systems to move staff on weekly pay onto fortnightly wages – leaving staff affected denied the first week's wages until after they eventually leave the company.

UNISON North West regional organiser Maria Moss said: "Most ISS workers do not have savings to draw on to tide them over. ISS's top managers don't seem to have any understanding of what life is like for the workers they employ on the minimum wage."

Meanwhile the same ISS staff will also be taking part in a strike ballot over the failure of ISS to pay them the agreed national rates of pay for NHS workers.

They will be encouraged by the recent victory of staff at Liverpool Women's Hospital where UNISON members employed by OCS took strike action, and as a result are now being paid the full NHS rates, winning a pay rise worth some £2,000 a year for fulltime staff.

The Guardian reports that an estimated 100,000 low-paid cleaners, porters, security guards and catering staff who work for private contractors in hospitals across England are being treated as "second-class employees", thanks to a growing pay divide between public and private sector workers.

Last year, as part of a three-year deal negotiated by health unions, the lowest-paid workers in the NHS were given a £2,000 pay rise . But the overwhelming majority of health staff employed on private contracts have not received a penny, according to UNISON.

Currently, UNISON says, many staff employed by private contractors are on the minimum wage, which is £8.21, equating to an annual salary of £16,052, or £1,600 a year less than what the lowest-paid worker in the public sector is paid.

STP plans ditched to make way for THREE 'Integrated Care Systems'

John Lister

Nottinghamshire is one of the eight "first wave" Integrated Care Systems being established by NHS England, and discussed at length in the NHS Long Term Plan (LTP) published in January.

It was also one that experimented with a short-term contract to enlist the services of US health insurance corporation Centene (headed in Britain by former high-flying NHS boss Samantha Jones) to help design new services, though there is now no sign of any continued US involvement.

Nottinghamshire's ICS appears to be functioning on a very different basis from the obsessive secrecy and efforts to ensure centralised control that have marred most other proposals billed as "integration".

Partly as a result of pressure from Nottingham's Labour-led City Council, under pressure from local campaigners, which walked away from the process last December, complaining of "lack of democratic oversight," the Leadership Board of the Nottingham and Nottinghamshire Integrated Care System (ICS) has agreed to hold its meetings in public, doing so for the first time in April.

It has also begun publishing its board papers and minutes of meetings.

The Leadership Board also agreed that rather than dividing Nottingham and Nottinghamshire into two "Integrated Care Systems" it will instead have three --- with a separate one for the city of Nottingham, one for Southern Nottinghamshire and another for mid Nottinghamshire. Whether this still complies with the notion of "integration" in any meaningful sense of the word is debateable.

However responding to these developments, the City Council agreed in April that it would rejoin the ICS as a full member – provided that the ICS agreed to bring in a system of unanimous voting on "any proposals that might lead to outsourcing or privatisation of NHS services."

Different from Long Term Plan

So it's already clear that the process is proving very different from that spelled out in the LTP. That describes a network of ICSs to cover the whole of England "growing out of the current network of Sustainability and Transformation Partnerships (STPs)," and takes a very different approach:

"Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area." (p29).

Far from streamlining, Nottinghamshire health chiefs appear to have bought an appearance of unity by adopting a fragmented model, in which not only the council but any one of the constituent bodies would potentially be able to exercise a veto, by preventing the required unanimous vote.

In other respects, too, the Nottingham and Nottinghamshire Health and Care Integrated Care System (ICS) System Operating Plan 2019/20 shows a complete departure from much of the original STP plan that was cobbled together during 2016, and rubber stamped by NHS England at the end of that year. That plan is understandably barely mentioned at all, given that it was based on assumptions that have already proved false, including:

- Reduce "mental emergency attendances" and readmissions over the next two years by 10% (p10)
- 20-40% reduction in non-elective admissions
- 15.1% reduction in A&E attendances
- 30.5% reduction in Non elective acute bed days
- 25% reduction in admissions to nursing and residential homes
- 9.8% reduction in secondary care elective referrals (p68)

The STP's authors expected these very substantial (and largely imaginary) reductions in acute activity (a reduction of 30% in south Nottinghamshire and 19.5% in mid-Nottinghamshire, p10) would make it possible to reduce numbers of acute hospital beds – by 200 (p68).

Specifically City Hospital was to be "downsized," with its estate reduced by 20%, with further estate sales at Kings Mill (p54).

Instead the plan was to provide care in (undefined) "alternative settings that are more appropriate for our citizens."

"Care will be reprovisioned to short term residential/ community beds, short term assessment beds, standard residential beds and also supported at home living." (p69)

The STP rubber stamped by NHS England at the end of that year. That plan is barely mentioned at all: it was based on assumptions that have already proved false

STP planned for cuts in staff

According to an 11-page annex to the STP (which now appears to be no longer available online) the plans also involved a 2.7% (562 FTE) overall reduction in workforce over 5 years, centred on acute services, with a proposed reduction of 647 staff in urgent care and 691 in planned care, despite an expected 9.3% increase in demand over the same period.

In fact NHS figures show that emergency admissions, total admissions and A&E attendances have each gone up over the past two years at both Nottingham University Hospitals and at Sherwood Forest Hospitals trust. Moreover the new Operating Plan (page 86) now expects future numbers of both emergency and elective admissions to increase even faster, by 5.6% and 3.8% respectively in 2019/20, and A&E attendances to increase by 3.3%

The staffing plans have also been quietly abandoned: between May 2016 and January 2018, both acute trusts increased their staff numbers – NUH by 15%, SFH by 7.7%: only the mental health trust (Nottinghamshire Healthcare Trust) slightly reduced its numbers of staff.

The ICS Operating Plan, which went to trust boards and governing bodies in April, now faces both ways on cuts. On page 32, a diagram calls for action to save £12m in 2019/20 by:

- Reduce A&E attendances
- Reduce emergency admissions
- Reduce long term placements
- Reduce long term placement costs

Under Urgent and Emergency Care, it seeks to save £14m, by

- Reduce bed days
- Reduce long term placements
- Reduce long term placement costs

Leadership Board of the Nottingham and Nottinghamshire Integrated Care System (ICS) has agreed to hold its meetings in public, publish its board papers and minutes

In addition, cuts in numbers of outpatient appointments are projected to save £10m, and reduction in Musculoskeletal (MKS) services is expected to save another £5m.

Mental health is also expected to save £5m – despite all the fine words in the Long Term Plan about improving access and imposing maximum waiting times for mental health care. Across the ICS there are vague proposals to save £9m from 'back office' services – which run the risk of dumping admin work onto clinical staff – and £10m from 'procurement'.

None of these proposed savings come with any detailed explanation, and there is a large caveat to the whole page highlighted in a red box which states **'Note: all opportunity figures (in bubbles) – £m– are gross, high level and indicative'.**

In other words they have little value.

Despite these apparent targets, the rest of the document appears to be proposing nothing but service improvements, and are inconsistent with the notional target of reducing spending.

Pinch of salt

However anyone seeking any serious analysis from the document should take it with a generous pinch of salt. The March meeting of the ICS Board (minutes published in April) urged anyone drafting documents always to accentuate the positive, even to the extent of inverting the facts:

"Where possible outcomes should be described as 'increases' rather than 'reductions' so they are described in a positive frame" (p4)

The same Board discussion seems to have reacted with alarm to the idea that resources might be redirected to deprived areas:

"It was queried as to whether the framework might drive resource to deprived areas which may have an impact on other areas. WS responded that this would need to be thought through; adding that reducing inequalities may mean spending differently."

Some of the most remarkable innovation is in the eccentric and jargonised use of language. We are left to puzzle for the meaning of the statement on page 40 that:

"Continuous improvement work continues on the front door pathways which started in December 2018. Working with the front door teams to allow access to back door discharge to assess services."

Is there any scope for patient care in between being speeded in through the front door and bundled out of the back? Further down the same page we find a discussion of "Options to develop additional acute capacity", which states:

"in addition to the focus on redesign, work is also being undertaken to develop potential options for the provision of additional acute capacity in case insufficient alternative schemes can be identified to mitigate the current forecast gap in capacity vs expected demand in 2019/20."

"Where possible outcomes should be described as 'increases' rather than 'reductions' so they are described in a positive frame"

Missing details

There is a striking lack of either estimated costs for some positive proposals to expand social care and reduced delayed discharge, or any workforce plan. So questions remain over plans to develop a "Home First Strategy" to provide "adequate capacity and capability within the domiciliary home care market," or the prospects if increasing "large care packages >27hrs/ week & 4x a day double ups". (p40)

Nor is there any estimate of costs or staffing implications in establishing "emergency ambulatory care", or reducing long lengths of stay in hospital "to ensure we have fewer than 199 patients in hospital with a length of stay more than 20 days". (p41)

The plan proposes to "Improve the acuity capability of community beds" but also increase utilisation of community beds "from 85 % to 92 % occupancy". (p42)

On mental health, where spending cuts are planned, the less than ambitious proposals include increasing provision of services for Children and Young People – to reach just over a third of the numbers needing support:

"Develop actions to support the 19/20 requirement of increasing access to 34% of estimated 2004 CYP prevalence" (p49)

The challenge of recruiting and adequately training sufficient mental health staff is referred to, but not the cost. Instead the ICS vaguely promises to "build towards" 1,700 new staff by 2020/21." (p50)

There are contradictory proposals to regularise use of private beds: "Transfer 16 spot purchased beds into a sub-contract in order to achieve better value and ensure care is closer to home." (p49).

Yet on the same page is a proposal to "develop a full business case for inpatient provision in Nottinghamshire Healthcare Trust." The scale of the problem of inappropriate out of area placements is enormous, with 20,488 bed days in 12 months to October 2018, and 150-180 additional beds needed by 2020/21).

The document continues in similar vein, with plans for the various provider trusts.

19% vacancy rate

But the problems faced by the trusts are glossed over. Nottingham University Hospitals for example is projecting a deficit of £68m for 2019/20: they have a 19% vacancy rate among nurses.

Mental health services are short of 158 staff including 60 nurses. Nottinghamshire is also short 77 GPs – yet the ICS plans to increase the rate of referrals of urgent care patients to GPs from 6% to 25%.

Far from any streamlined, no nonsense integration of services the ICS confirms that Nottinghamshire's NHS remains divided on many levels, locked in a crisis lacking staff, funds and beds, and dogged by continued production of hopelessly vague and unrealistic plans which are discarded some time later without learning any lessons.

■ In future issues of ***The Lowdown*** we will investigate other ICS plans to see if this is the norm.

Why are NHS mental health services still in crisis?

One in four people will experience a mental health problem each year, but most go untreated. Extra funding and new approaches have repeatedly been promised by ministers and by NHS England, but a recent Parliamentary assessment revealed that the service is still letting huge numbers of mental health patients down, why is this?

Summary:

Staffing levels are not rising with demand - scope and standards of care falling

Funding has been insufficient, and money has not reached patients

Our society is not addressing the root causes of ill health, over relying on drug solutions

Targets to treat mental health patients with same priority have been missed

Planners of care don't adequately involve people with a lived experience of mental health

NHS mental health beds have been cut and services outsourced

Rising number of patients

A recent study looking at young people found a six-fold increase over the last two decades, in the proportion of 4-24 year olds who have a long-standing mental health condition.

Commenting on the Nuffield Trust research, Dr Dougal Hargreaves said

"We know that there is already a growing crisis in the availability of Child and Adolescent Mental Health Services, with many more children and young people needing treatment than there are services to provide it."

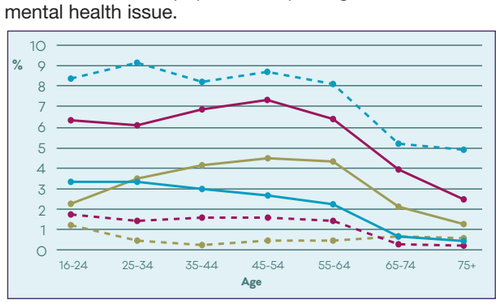
The authors suggest that part of the reason for the growth in demand is the willingness to admit problems.

The evidence also shows a steady rise in mental health issues across the population as a whole.

Economic uncertainty, the influence of social media and rising expectations of life have been suggested as factors.

92% of mental health trusts said in a recent survey that changes to universal credit and benefits are increasing demand for services, as are loneliness, homelessness and wider deprivation.

The most recent figures from NHS digital (2014) shows 9.3% of the population reporting a common mental health issue.



Prevalence of common mental health problems by age, from Mental Health Foundation Fundamental Facts about mental health 2016

The most recent figures from NHS digital (2014) shows 9.3% of the population reporting a common mental health issue

Staff numbers have not kept up with demand

In 2013 there was 1 mental health doctor for every 186 patients accessing services. In 2018 this has fallen to 1 for every 253 patients.

The number of nurses per patient has also dropped. In 2013 there was 1 mental health nurse for every 29 of patients accessing services, by 2018 that had fallen to 1 for every 39 patients.

10% of specialist mental health posts are unfilled.

A survey by UNISON of staff working in mental health found that staff shortages were:

- a major factor preventing individuals from accessing services early (74 per cent)
- a reason for the increased frequency of violent incidents experienced in the past year (87 per cent)
- a reason for staff having to work unpaid overtime (57 per cent).

Last year it was reported that two thousand mental health staff a month are leaving their posts in the NHS in England, according to figures from the Department of Health and Social Care (DHSC).

Funding is insufficient

An analysis of the most recent budget (2018) by economists at the Health Foundation noted that,

'Extra investment in mental health services will see funding grow broadly in line with the total health budget but this will mean simply maintaining the status quo, which sees just 4 in 10 people who need it receive mental health support. To see some improvement, with provision increasing to 7 in 10, the service would need an extra £1.5bn on top of what the chancellor has announced."

An overwhelming majority (81%) of trust leaders said they are not able to meet current demand for community CAMHS and more than half (58%) said the same for adult community mental health services; more than half (56%) could not meet demand for crisis resolution teams.

Commissioners don't involve people with a lived experience of mental health

A report by the charity Rethink found that only 1% of clinical commissioning groups co-produce their mental heath services with users and carers, they concluded

"Decisions about complex care need to involve the people using them." CCGs are failing to adopt co-production despite the fact that it was set out as the standard approach in the mental health strategy produced by NHS England.

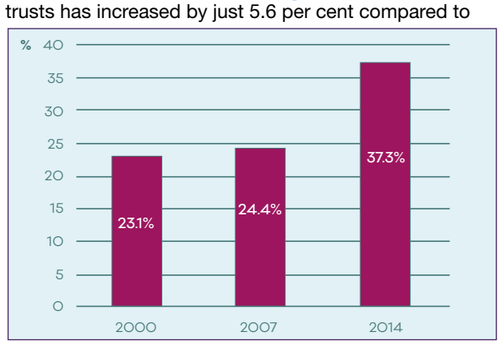
Mental health is still given less priority than physical health

There is less stigma attached to mental health services, but they only received 13 per cent of the NHS budget despite the fact that mental ill health accounts for 23 per cent of the disease burden.

For three years in a row, 40 per cent of mental health trusts received a cut in their funding (2013-2016) according to research by the Kings Fund. In the last year (2017-18) 21 per cent still suffered a fall in income.

Overall, since 2012/13, funding for mental health trusts has increased by just 5.6 per cent compared to an increase of 16.8 per cent for acute hospitals.

This is despite the government have stating its commitment towards achieving parity between mental and physical health back in 2011, and has led to accusations that mental health funding is not reaching patients and according to a Nuffield Trust analysis is being diverted to cover outstanding debts.



Percentage of people with common mental health problems in 2000, 2007 and 2014 receiving treatment, from Mental Health Foundation Fundamental Facts about mental health 2016

NHS Providers infographic 2019

91% of trusts blamed council cuts as a reason for more demand for mental health services

Closure of mental health beds and other services

The number of beds for mental health patients in England has slumped by nearly 3,000 (-13%) since 2013.

Official figures show that the number of beds for those with some of the most serious conditions – including psychosis, serious depression leading to suicidal feelings and eating disorders – has fallen from 26,448 in 2009 to 18,082 in 2018.

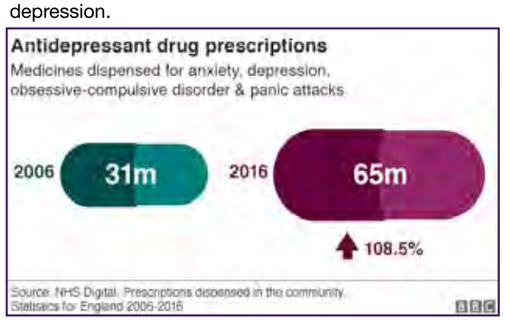
91% of trusts blamed council cuts as a reason for more demand for mental health services.

"Cuts to services funded by local authorities also mean that preventative approaches and early intervention services are less available. Mental health leaders pointed to rising demand during winter, but it is clear that these pressures on services are a year-round phenomenon." - (NHS Providers survey of trusts).

Neglecting the root causes and over relying on drug solutions

As a society we are not adequately addressing the root cause of mental health; economic uncertainty, problems with housing, social isolation, relationship breakdown and chronic disease.

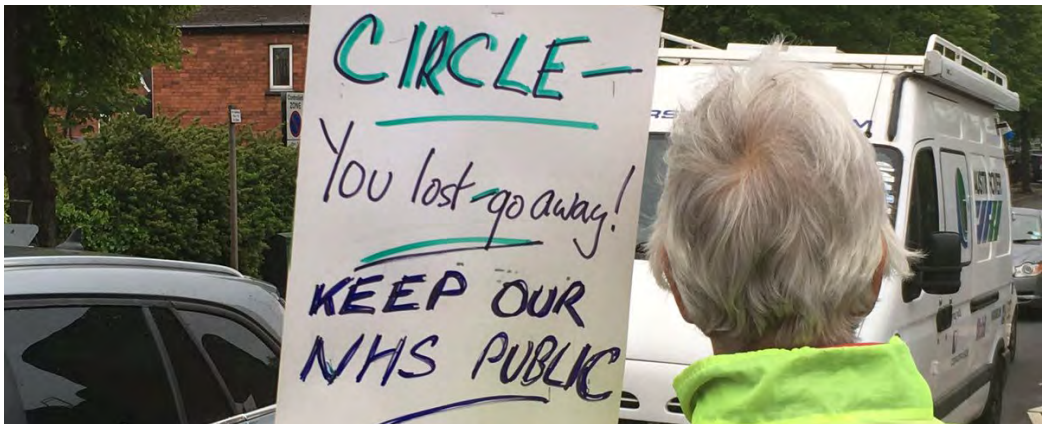
More people are sleeping rough and one in five of us have mental health issues connected to housing, changes to benefits have increased suicides, a million children are living with parent who is addicted to alcohol and two fifths of people in care homes suffer depression.



THE lowdown

Health news, analysis and campaigns.
NUMBER 2, May 11 2019

Informing, alerting and empowering NHS staff and campaigners



Circle launches fresh court challenge over lost contract

Circle Healthcare, the private company currently running the Treatment Centre on Nottingham University Hospitals Trust's Queens Medical Centre campus will go to court on May 15 to protect its profits. It has launched a legal challenge to the Rushcliffe Clinical Commissioning Group (CCG) decision to award the £320m contract to the Nottingham University Hospitals trust.

Having lost out twice to the NUH Trust in the new contract to run Treatment Centre services, Circle is now going to court for a second time, claiming the Trust can't possibly treat NHS patients for less money, and that bringing the contract back in-house would be "unrealistic" and "not in patients' interests".

One especially bizarre claim by Circle, a company owned by hedge funds that has yet to deliver a profit, and whose private hospitals depend upon NHS-funded patients was that NUH could not be seen as reliable because it was running a deficit.

The controversial company has had a number of major failures in the past, not least the collapse of acute dermatology services in Nottingham after they took over that contract.

Circle's action is due to be heard on Wed 15th May in the High Court's Rolls Building in London's Fetter Lane.

Circle now allege that the cost of in-house services would be higher, due to staff benefiting from "improved NHS terms" – an admission that they have been underpaying staff up to now.

The in-house bid has been approved both by the CCG and NHS Improvement's Regional Director of Finance.

Campaigners are stepping up the pressure to ensure Circle don't get another chance.

Hundreds of leaflets were handed out on May 9 in an early morning lobby outside the QMC by 20-30 campaigners including Keep Our NHS Public, UNISON Health NUH branch and officials, Nottingham Unite Health, Unite Community and a newly elected local councillor.

UNISON are starting a campaign to persuade Circle they will be better off in-house (frontline staff wages are better for starters!). UNISON are also initiating an on-line petition

More surprising support came at a meeting of the Integrated Care System Board that day, where the Chair agreed to circulate a campaign leaflet prior to a discussion on Best Value, and KONP have now been invited to a separate meeting with Board members.

Sodexo workers win pay deal after 2-day strike action

Following two days of strike action at the beginning of May, catering staff employed by contractors Sodexo at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust have been offered a pay deal matching the increases for NHS staff agreed to in 2018. The action was jointly coordinated by UNISON and the GMB.

70 NHS catering staff members were had been transferred to Sodexo when the trust privatised the service in January 2017. UNISON now argues that this has cost each individual around £1,000 per year, because their pay did not automatically follow national NHS pay scales.

The strike action at Doncaster Royal Infirmary and Bassetlaw Hospital has been part of a series of similar recent actions taken by trade unions against a variety of private contractors that have refused to keep staff on equivalent pay to NHS national rates.

Last month support staff at Liverpool Women's Hospital also won an agreement from contractors OCS to increase pay to NHS levels, in a settlement worth as much as £2,000 to some staff.

IN THIS ISSUE

Public mood hardens against private firms running the NHS

Paul Evans

160,000 people have called on the government to end the market driven NHS, but firms dispute that this shows that the public are rejecting private sector involvement.

A consultation set up by NHS England to invite views about plans to re-shape the NHS has received their biggest ever response from the public. A key part of the listening exercise surrounded plans to remove the rules that currently force the NHS to compete with the private sector and charities for contracts.

Testing the popularity of outsourcing the campaign group 38 degrees asked 170,000 of their members whether "local health services should typically be run by the NHS, not private companies", an overwhelming 97 per cent agreed or strongly agreed in an online survey.

The group have published their survey ahead of the official consultation response from NHS England.

Countering the survey findings, David Hare, the CEO of the Independent Healthcare Providers Network said in comments to the HSJ, that they were out of step with other polling "credible research organisations such as ComRes and Ipsos MORI has shown time and time again that a representative sample of the public are entirely comfortable with independent organisations delivering NHS care".

Newest evidence

However, an analysis of the most recent polls reveals that the public are becoming far cooler about the idea of firms delivering NHS care. Ipsos Mori found in their 2017 public poll that there has been an increase in the number of people who prefer to use NHS services – 55%, up from 39% in the 2014 British social attitudes survey.

Opting for the NHS over private providers is an even more telling choice by the public given the pressures on NHS. For the first-time satisfaction rates are falling, but the public's belief in the core principles of the NHS is holding fast.

Nine out of ten still back an NHS that is free at the point of access and provides a comprehensive service to everyone.

There are also signs that voters are more likely to back nationalization policies over those that give the private sector more control. YouGov poll found that only 10% of the public believe the NHS should be privatized and run by private companies, with 83% saying it should be nationalized and "run in the public sector"

It is true that, at one stage polls seemed to show a small majority of the public to be indifferent about how NHS care was delivered - as long as it was free at the point of use.

A YouGov poll found only 10% of the public believe the NHS should be privatized, with 83% saying it should be nationalized and "run in the public sector"

However, a succession of spectacular outsourcing failures has crumpled public confidence. Firms that haven't made profits have frequently dropped contracts, leaving the NHS to resurrect service provision. Recently Virgin announced it is to walk away early from its £270m contract to provide services to frail older people in Staffordshire.

Back in 2014 Serco abandoned all its NHS work after profit margins were squeezed and accusations that it fiddled performance figures and left GP services in Cornwall dangerously understaffed.

A year later Circle gave up running an entire NHS hospital in Cambridgeshire after the health watchdog produced a damning report on its failings *(see page 5).

More recently the collapse of Carillion and the repeated problems with Capita and G4S contracts have made them household names and piled reputational damage on to the outsourcing project.

The public view of private companies is becoming more nuanced. The Panama Papers and other tax scandals explain why nine out of ten people believe tax avoidance by large companies is morally wrong.

However, extensive cuts and restricted spending on public services have pushed more commissioners towards the private sector, but the shock of this long period of austerity has also now shifted opinions on these key national policies.

Only one-fifth now think that there is a real need to cut spending on public services to pay off the national debt and most people would pay extra tax to see spending on the NHS rise.

Campaigns move governments

In the months after the Health and Social Care Act 2012 was passed the government confidently launched successive new ways to involve private firms, but now, seven years on it seems that most privatisation projects in the NHS are toxic to the public.

In the past few months a plan to privatise PET scanning in Oxford has resulted in a vigorous local campaign, pulling in MPs and councillors to back the opposition. NHS England has already attempted one climb down, but the local objectors are yet to be convinced. In fact, after announcing that it is trying to persuade the government to scrap the section 75 rules that enforce competition, it is the credibility of NHS England that is on the line.

They must convince a battle hardened constituency of NHS campaigners that they are genuinely steering the NHS away from markets and the privateers. However, the emergence of new privatisation projects, like that in Oxford are raising real doubts.

We Own it and Keep Our NHS Public have worked together to encourage the public to answer NHS England's consultation. They encouraged supporters to send NHS leaders a letter that reads

"I'm really pleased that you're calling on the government to abolish section 75 of the NHS Act….But I want you to go further. I want an NHS which is publicly provided, publicly funded, and publicly accountable."

Campaign groups suspect that the NHS integration project will still provide opportunities for private companies to expand their control.

They cite the NHS contract for Integrated Care Providers as evidence, as it gives private companies the chance to take on the lead budget holding role. Even if this is unlikely, say campaigners the new local partnerships of providers also lack accountability and proper governance.

In the last two years petitions against privatisation have collected millions of signatures and provoked a handful of judicial reviews.

The public have become steely and active in their opposition. After being taken to the high court there is no doubt that NHS leaders are more realistic about the public mood.

NHS England are also clear in their view that competition and market rules are dysfunctional, working against their new integration plan for the NHS. The public want them to go further, to banish an era of private sector incursions and you can bet that campaigning won't stop until they do.

Pensioners challenge Staffs cull of community beds

The campaign to halt plans to axe half of the community hospital beds in north Staffordshire and Stoke on Trent, with the total closure of beds in four of the five hospitals, which we reported in the first pilot issue of ***The Lowdown***, is continuing, and now the North Staffs Pensioners Convention (NSPC) has published a detailed response.

The two clinical commissioning groups published slightly revised plans last December, which would result in some hospital sites being sold off and all the beds at Leek, Longton, Cheadle and Bradwell hospitals set to close for good

These were the latest retread of the unpopular **'My Care My Way - Home First'** proposals which were challenged by Stoke on Trent city council and subsequently heavily criticised in December 2017 by the Independent Reconfiguration Panel, which noted that:

"Nearly three years after proposing the new model, the NHS has not yet demonstrated the case for change.

"The NHS has failed so far to show the capabilities required properly to implement My Care My Way - Home First […]

"Although there has been extra investment in out-of-hospital services, the closure of community beds to date is associated with cost cutting rather than the implementation of better services with improved outcomes for patients."

The IRP also commented that "Without a solid case for change, the NHS has not established a robust programme for change and experienced a number of false starts. The bed modelling presented to the Committee in September 2015, has proved entirely incorrect and misleading."

And it agreed with the council and campaigners in dismissing the specious claims by the CCGs that the closures they had implemented were only "temporary":

"The myth of temporary closures is reinforced by the NHS confirming that they have no plans to reopen the beds and that their financial plans for the last two years rely on almost £10m of savings from the closures."

However the Panel decided not to carry out a full review or call for the CCGs' plans to be dropped, despite renewed local calls for the beds to be reopened.

The NSPC response, published in their May bulletin, underlines the consequences of the CCGs' irresponsible attempts to make cuts by closing 187 beds, and commissioning 55 places in privately run care homes:

"The impact of your reckless closure of Community Hospital beds has already been felt across the local Health system – particularly on the Royal Stoke Hospital and waiting times at the Accident and Emergency department."

They go on to show the problem of relying on poor quality care homes

"in practice, you have commissioned beds in Brighton House – that found Legionella in the water pipes, and Stadium Court that was deemed inadequate by the CQC and closed to new entrants. […] Of 86 beds that you commission from the independent care home sector, 51 are in homes that require improvement. This is a complete failure to safeguard the people in your care."

So far there is little sign of any change of direction by the CCGs, who seem determined to add further proof for campaigners who argue that NHS rhetoric about "integration" and new services is simply a smokescreen for greater dependence on profit-seeking care homes and short-sighted cutbacks.

Virgin gives up on underfunded Staffs contract

Virgin Care is set to abandon its community care contract in East Staffordshire by 2020 after failing to reach a funding agreement with the CCG.

The seven-year fixed price contract is worth £270m and covers care for patients with long-term health conditions and frail, older people.

East Staffordshire CCG signed the deal - which began in May 2016, arguing it could not shoulder the cost of integrating the service. Virgin Care took on the role of prime provider, which meant that it both commissioned and provided services.

However, in October 2018, following an 18 month dispute over funding, Virgin Care terminated all the commissioning elements, although it continued to provide community nursing, specialist nursing and care coordination.

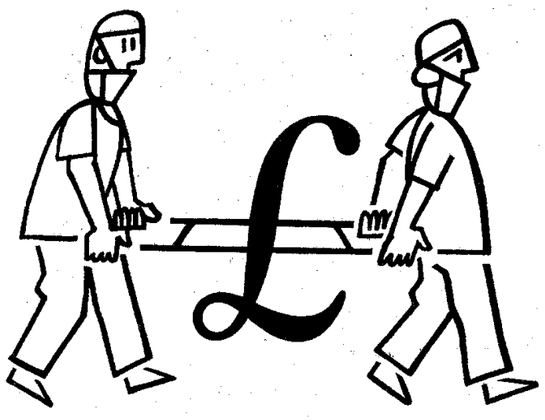
The CCG had to take over direct control of the sub-contracts that Virgin had put in place, whilst negotiations took place, but agreement could not be reached.

The private provider was reported by the HSJ to be demanding an extra £5m. Finally Virgin Care sent a 12 month termination notice to the CCG.

Nearby Burton Hospitals Foundation Trust was affected by the dispute as Virgin subcontracts services from the trust and its finances were put in jeopardy because contracts were stalled.

Under NHS contracts, private companies can abandon contracts with no penalties. Virgin Care is just the most recent company to have done so for financial reasons. Other terminated contracts include those in GP services, out-of-hours services and hospital services (see facing page for more examples).

The Staffordshire Improving Lives programme was claimed to give patients more control of their own care, including support using telecare and remote monitoring technologies.



Under NHS contracts, private companies can abandon contracts with no penalties. Virgin Care is just the most recent company to have done so

The contract was expected to cover 38,000 people with long term conditions, as well as an estimated 6,000 elderly people. It included a measurement of performance against patient outcomes such as rate of falls, admissions into hospital, diabetes blood test management and patient mortality.

But since there is not enough money in the pot for either the CCG or Virgin to deliver the contract, the future of these services must be in doubt.

Plan for public-private mental health link-up is finally scrapped

A long-delayed innovative collaboration between public and private providers for child and adolescent mental health services (CAMHS) in Kent, Surrey and Sussex has been abandoned, according to the HSJ.

The pilot, part of NHS England's Mental Health Forward View, was meant to go live in October 2017 with Surrey and Borders Partnership Foundation Trust as its lead provider, taking control of the budget responsibility for decision making for tertiary mental health care, including adult secure care and tier four CAMHS.

Under the scheme the lead provider then partners with other organisations and would have included the largest number of private providers in the country including; Elysium Healthcare, Huntercombe Group, Priory Healthcare and Cygnet Healthcare.

With the exception of Elysium Healthcare, all these organisations have received highly critical reports from the Care Quality Commission (CQC) in recent years.

An initial delay put the start date back to October 2018. According to HSJ, the staff were told at Christmas of the scrapping of the pilot, but no public announcement has been made. The pilot is not listed on the NHS England's website.

The reason for the pilot being dropped are numerous, according to the trust. The structure, with a lead provider, is still very much way that mental health care is set to develop. (see following story)

Problems with private providers

The Priory Group has been sanctioned in recent times for the deaths of three adolescents - Amy El-Keira at Ticehurst, Sara Green in Priory Royal, Cheadle, and George Werb in the company's hospital in Southampton.

More recently in February 2019, the Priory's hospital for children with learning disabilities in High Wycombe was closed, following a CQC report that gave the unit an overall rating of 'inadequate'.

The hospital had only opened in April 2018 and catered for children aged 13 to 17 with learning disabilities and/or autism.

In 2018, two of the company's hospitals, its Roehampton hospital in Wandsworth and its hospital in Southgate, North London, received very critical CQC reports. Both were rated "requires improvement" overall by the CQC, following unannounced inspections.

The CQC rated the Southgate hospital as "inadequate" for safety and noted several concerns across its child and adolescent mental health services, acute adult wards and substance misuse services.

In December 2018, an inspection by the CQC of Huntercombe's hospital in Norwich found serious concerns. The CQC took immediate action to protect those using the service, including enforcement action to remove the registration for the hospital.

The Huntercombe Group then closed the service and the children and adolescents had to be found places elsewhere.

The CQC issued a highly critical report in early 2019 on Cygnet Healthcare's CAMHS' unit at its hospital at Godden Green, in Kent, and Cygnet closed its CAMHS unit in Woking in late 2017 following a CQC inspection.

The terminators: seven companies that walked away from NHS contracts

In 2012 **Circle** won a ten-year contract to run the NHS Hinchingbrooke hospital, but pulled out after only two years following a lack of financial success and damning reports from Care Quality Commission (CQC).

The CQC raised serious concerns about care quality, management and the culture at the hospital. It found a catalogue of serious failings that put patients in danger and delayed pain relief. The hospital was put in to special measures; the first time the CQC had taken this step.

In December 2013 **Serco** announced that it would be pulling out of its contract to run Braintree hospital: the contract was handed back to Mid Essex Hospital Trust, nearly a year early.

Also in December 2013 **Serco** announced that its contract to provide out-of-hours care in Cornwall for Kernow CCG would end 18 months early. The contract had been dogged with controversy; Serco had to admit that some of its staff had falsified data to make the company's performance appear better than it was and whistleblowers had raised concerns about poor staffing levels.

Image: The Poke

The Public Accounts Committee reported the service to be falling "unacceptably short" of essential standards of quality and safety. In 2013 Serco unsuccessfully tried to sub-contract the work to Devon Doctors, the GP consortium that had failed to win the original bid; Serco had won the bid as it was cheaper.

The company's other major contract with the NHS for community care in Suffolk, did not produce the profits the company was hoping for.

By August 2014, Serco announced that it was withdrawing from the NHS clinical services market altogether.

In early September 2017, **Primecare**, which had been awarded one of the first integrated NHS 111 and GP out-of-hours services contracts, announced that it would be handing back the contract to the NHS.

Initially this was to be in July 2018, but then in late September 2017 the company invoked a clause in the contract that meant it only had to give three-month notice.

After only seven months, Primecare was placed in special measures when its services in East Kent were rated "inadequate" by the Care Quality Commission. Failings included not assessing risks to patients' health and not having enough staff to meet patient needs.

Care UK terminated a contract to provide NHS GP out-of-hours services in April 2015. The contract was to provide care in conjunction with Portsmouth Health Limited (a group of local GPs), however the deal, which began in 2012, proved to be loss-making and so Care UK ended its involvement before the end of the contract. Similar tensions around cost-cutting were reported to be at the heart of the difficulties experienced by the out-of-hours company

Private companies are closing GP practices in areas where it is difficult to make a profit. In Brighton and Hove, **The Practice Group** announced in January 2016 that it will terminate its contract for five GP surgeries in the city at the end of June, leaving 11,500 patients looking for a new GP.

Over the years, The Practice Group, which runs around 50 GP surgeries, has also closed a surgery in Camden Road, London, the Maybury surgery in Woking, the Brandon Street practice in Leicester and the Arboretum surgery in Nottingham.

All these surgeries were in areas of high deprivation, where it is difficult to make money. The Practice Group defended terminating the contracts and closing services, saying that loss-making activities were unsustainable.

In late September 2017, the private ambulance company, **Private Ambulance Service** contracted to run non-emergency patient transport from hospitals in Bedfordshire and Hertfordshire went into administration, with trading ceasing 9 October 2017.

The business, which had 126 vehicles and employed 300 people, took over the contract in April 2017.

Problems had been reported with the service, including a report in the Herts Advertiser in July 2017 about Herts Valleys CCG issuing an apology after ongoing problems with the performance of the company, including leaving vulnerable patients stuck in their homes or in hospital for hours waiting for transport.

In October 2016, **Greenbrook Healthcare** announced its intention to hand back an APMS contract for five GP surgeries in west London nine months before the end of the contract. This put around 27,000 patients at risk of losing their GP.

Greenbrook had been in discussions with NHS England since early 2016, but no additional funding had been offered. The company stated that due to rising demand and problems with GP retention the contracts had become "unfit for purpose".

Private providers to be to be given say on £2 billion mental health budget

Plans to hand over millions of pounds worth of specialised commissioning for mental health, learning disabilities and autism to other organisations, including those in the private sector, have been outlined by NHS England.

According to HSJ, plans were outlined in a letter sent to chief executives of both NHS and independent sector providers.

The care model has been piloted since 2016 in 14 areas. It will now be rolled out across England, with a target of 75% by 2020 and all England coverage by 2022.

The new model involves the appointment of a lead provider who will be responsible for the budget and commissioning of services for a designated area.

It is part of the national project to "integrate" services, but the prominence of private providers in this sector raises the possibility of a commercial provider being given the lead provider role.

The lead provider will assume responsibility for commissioning functions, such as workforce planning and quality assurance, and thus control of a specialised commissioning budget of tens of millions.

The 2016 programme covered specialised commissioning of child and adolescent mental health services (CAMHS), adult secure care, and adult eating disorder services in 14 pilot areas.

The new plan will now also include learning disabilities and autism.

The new model of care in mental health is part of NHS England's push for integrated care and the development of integrated care systems and partnerships across England.

Tight-fisted new prescribing guidelines fail to make savings

Hannah Flynn

NHS England's latest attempt to reduce the availability of treatment to patients was ill-conceived and always doomed to fail.

Ever since the NHS founder, Aneurin Bevan resigned from cabinet over the introduction of NHS fees 1951, successive Governments have pushed against the principle that NHS treatment should be free at the point of use.

Experience around the world confirms that imposing even a relatively small charge is guaranteed to reduce the numbers of patients accessing a drug or treatment, especially the poorest, regardless of how much they might need the drug.

The latest attempt by NHS England to restrict GP prescribing of OTC medicines for 'self-limiting' conditions and make patients pay for medicines available over the counter (OTC), was recently revealed to have made just a quarter of the forecast £100m annual savings.

New pharmacy minister Seema Kennedy MP was forced to admit in a statement that spending on OTC medicines had not fallen as much as originally forecast.

Dr Andrew Green, BMA GP committee clinical and prescribing lead told ***The Lowdown*** the savings envisaged "were always ambitious, because GPs were already advising patients to buy over-the-counter medications where appropriate, but prescribing when they believed there was a need."

He questioned whether other savings had been made by avoiding GP appointments being made, but the statement by Ms Kennedy revealed no assessment had been made of this.

Pharmacists reported no increase in the number of OTC sales in the past year, according to trade publication Chemist+Druggist.

Sandra Gidley, chair of the English Pharmacy Board of the Royal Pharmaceutical Society commented: "In practice GPs have taken a very pragmatic view on [these prescribing guidelines] and appear to have carried on prescribing items if they believe the patient won't be able to buy the item."

"It would be interesting to see if there are differences in prescribing patterns between areas with minor ailments schemes and those without," she added.

While some common drugs like paracetamol can be bought more cheaply over the counter than on prescription, only with a prescription can patients access more than two days-worth of paracetamol, meaning that this is still useful to those required to take it daily, especially if they are entitled to free prescriptions.

Measuring Impact

Pointing patients to pharmacy services, as opposed to their GP practice has always been justified with the claim that it will free up GPs to deal with more needy patients. This can be the case, if alternative services adequately meet need. The minor ailments scheme for example, provides OTC drugs free for those who need them, without prescription.

Minor ailment schemes availability is patchy in England: however they are commissioned across Scotland and Wales, where prescriptions are already free. A PricewaterhouseCoopers report published in 2016 showed minor ailments schemes in England were worth nearly £50 million, nearly twice what NHS England's latest prescribing restrictions achieved.

So not only was it possible to save more money, it was possible to do so while ensuring treatment was free at the point of use. Most of these savings were from reducing GP appointments made by these patients.

This claim was further backed up by a study done across Scotland last year that demonstrated 85.9% of patients who accessed a pharmacy-based minor ailments scheme required no other NHS service, and just 6.4% of patients went on to see their GP.

A further study published in 2017 demonstrated the schemes were good at reaching those who needed them most, with just 8% of patients who used a minor ailments scheme in England saying they would have purchased the medicine over the counter if the scheme had not been available. Over half (61%) of consultations were for children under the age of 16, a group entitled to free prescriptions anyway.

"In practice GPs appear to have carried on prescribing items if they believe the patient won't be able to buy the item."

Unnecessary meddling

Interestingly, the All Wales Prescribing Advisory Group, an advisory body to the Welsh government withdrew its support for introducing similar prescribing guidelines in Wales, just days after the minister made her statement.

Does the existence of minor ailments schemes make the restriction of prescribing for OTC medicines unnecessary? The decision in Wales suggests some may think so. Either way, it is clear that any attempts to undermine the principle of providing treatment to NHS patients free at the point of use, will often result in driving up costs elsewhere.

Hancock's half-baked data – and the groups who provide it

Matt Hancock's appearance at a Taxpayers' Alliance (TPA) event last month raised eyebrows. As many on twitter rightly asked, why is the Health Secretary teaming up with a lobby group that has long wanted to do away a state-funded healthcare system?

Tamasin Cave investigates.

The TPA's latest report, Embracing technology in health and social care, for which Hancock wrote the foreword, marks a departure for the lobby group away from its usual demand for cuts. (Asked why the change in direction, its CEO said only "austerity is over, so...").

Instead the TPA report calls for more investment in technology and increased automation to save the NHS money. In this, it has joined an established network of lobbyists championing the idea that technology will save the NHS, each echoing the assertions of the last.

The TPA's figures, for example, are lifted from a 2018 report by the 'progressive' think tank, the IPPR, including its 'key finding' that the NHS could save £12.5bn a year through improved productivity from automation.

(The IPPR was quick to distance itself from the TPA, saying that it has 'twisted' its research and its proposals for the NHS were 'very different'. In truth, there's not much between the IPPR's press release last year and the recent TPA one).

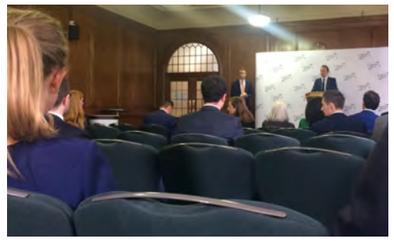
Unexplained figures

Last year's IPPR's report came in for criticism, however, including in the BMJ, for showing 'no workings or figures, no appendices to explain how these extraordinary efficiencies were calculated'. So, where did the IPPR (and consequently the TPA) get its figures on the potential for technology to save the NHS billions?

From US management consultants, McKinsey. Tom Kibasi, the IPPR's current director was more than a decade at McKinsey where he led its work on 'innovative healthcare delivery', so perhaps this is no surprise.

The IPPR says the figures in its report, Better health and care for all: A 10-point plan for the 2020s, are the result of analysis of work by McKinsey on the potential for automation across industries, including healthcare.

They are not the only ones, however, to rely on McKinsey's number crunching when it comes to the promise of health tech.



Above: McKinsey-sponsored bright lights and full colour as Penny Dash (left) listens to Matthew Swindells getting ready to jump ship back to the private sector. Below, a gloomy room and empty seats for Hancock and the obscurely-funded "Taxpayers Alliance"

The firm has also produced similar for NHS England. An 'evidence summary' by McKinsey from 2014, which was released under freedom of information law, said that with a substantial investment in technology the NHS could achieve savings of between £8.3 billion and £13.7 billion.

NHS England's then national director for tech, Tim Kelsey – formerly of McKinsey – used the figures to call for the NHS to spend billions on embracing digital technology. McKinsey also provided the NHS with 22 recommendations to drive its adoption.

No evidence at all

The problem is that the figures McKinsey provided to NHS England, according to an academic in health information, were 'an educated guess'. "It's not evidence at all," Dr Philip Scott, a senior lecturer at the University of Portsmouth's Centre for Healthcare Modelling and Informatics, told Digital Health News having looked at McKinsey's summary for NHS England.

The suggestion that investment in technology could save up to £13.7 billion was "an unfounded claim", said Dr Scott. "It's not based on anybody actually having done it. It's based on what we think it ought to do." The potential savings had "the ring of being very optimistic estimates," he said.

Regardless, the message that digitisation and automation are the answer to the NHS's problems continues to be repeated without question, particularly in policy-making circles.

Just weeks before the TPA event, a day-long health policy conference in Westminster – sponsored by McKinsey – discussed the inevitability of technology 'transforming' healthcare.

Dash for technology

Penny Dash, a senior partner at McKinsey who has long been involved in market reform of the NHS, spoke alongside NHS England's outgoing deputy CEO, Matthew Swindell, who is rejoining the private sector. She explained how healthcare leaders can 'eliminate the roadblocks' to technological change.

Next month, Hancock will also be guest of honour at the annual health conference of the free market think tank Reform (funded by, among others, McKinsey). The topic of the conference? 'Unlocking the promise of digital health'.

For years, McKinsey has been a leading advocate for the use of more technology in healthcare, including the NHS.

It was involved, for example, in Tony Blair's £12bn NHS National Programme for IT, now know as the 'biggest IT failure ever seen'.

It was also involved in discussions around the NHS's doomed data-sharing project, Care.data, which was also eventually scrapped.

Driven by lobbying

Writing in the BMJ about his concerns with the IPPR report, David Oliver concluded that 'over claiming about technology' is more likely to be 'driven by industry lobbying, marketing [and] the financial bottom line', than by evidence.

Despite McKinsey's heavy involvement in the health service – in 2012 it was described as the 'firm that hijacked the NHS for its extensive involvement in Andrew Lansley's disastrous market reforms – it earns most of its money consulting for the private sector.

It has always refused to name its clients, but they are known to include some of the world's largest healthcare and drugs firms.

So, while we absolutely should demand to know who is behind the Taxpayers' Alliance and its recent lobbying for health tech, it's arguably more important that we know who else McKinsey works for.

Secret plans and dodgy figures in Leicestershire

John Lister

Secrecy surrounds recent development of NHS plans in Leicestershire. Local NHS bosses keep developing new flawed plans without ever learning the lessons of the previous ones. Now campaigners complain NHS chiefs are refusing to publish a key document: perhaps this is because after two previous failures they know it cannot withstand public scrutiny.

Leicester, Leicestershire and Rutland (LLR)) has just one acute hospitals trust, University Hospitals of Leicester (UHL) on three sites: for many years there have been plans to reduce this to two, with the loss of acute beds and services at Leicester General Hospital.

Proposals for this, running alongside cutbacks in community hospital services – predate NHS England's ***Five Year Forward View*** in 2014. By summer 2014 the optimistically-named LLR "Better Care Together" project ("a partnership of Health and Social Care") had already published its Five Year Strategy, followed in December by a "Strategic Outline Case". This insisted that:

"the path laid out in the five year strategy is ***the only way of achieving clinical and financial sustainability***" (p9).

It took less than two years to prove this, and much of the document, wrong.

The SOC had bravely promised to produce a series of business cases, which would apparently involve working through plans "in granular detail". None have yet appeared.

Vague

Most proposals other than the precise number of beds to close, were vague: key to the SOC was a "left shift," to care delivered outside of hospitals: "a vision for the future in which the community model of care is transformed, with far more provision of care taking place outside hospital in primary, community and home care settings." (p10)

There were neither concrete proposals nor the necessary investment to expand community and primary care services to take on the extra work. Nonetheless the SOC anticipated that these changes would lead to:

"the reduction of 427 beds at UHL [24% of the total of the trust's 1773 day and overnight beds], and allow the organisation to achieve its vision of moving from 3 to 2 acute sites by 2018/19, a core strategic objective." (p10)

The SOC's almost incoherent "Bed reconfiguration summary" went further, and argued the need to reduce UHL bed provision by an even higher number:

"In total, actions need to be taken across LLR to remove 571 beds from UHL. This is made up of:

UHLs detailed bed reduction

Figure 47: Profiled bed reductions

Year	Physical beds reduced
15/16	203
16/17	122
17/18	61
18/19	41
Total	**427**

Figures from the STP

"462 beds related to UHL efficiency reductions and left shift of sub-acute patients …

"109 beds related to workstream efficiency reductions. Overall, this will mean that UHL's bed base will reduce by 427 beds because some of this reduction is required to reduce anticipated activity growth over the five years of the plan." (p70)

The SOC promised to produce a series of business cases, which would apparently involve working through plans "in granular detail". None have yet appeared.

The assumptions underlying this massive, sustained reduction in acute bed numbers at a time of increasing demand for health care were in the realm of fantasy:

"UHL and LPT [Leicestershire Partnership Trust] have agreed that 250 beds worth of patients can be cared for outside of an acute setting. The 250 beds are broken down as follows:

"170 where patients can be treated by expanded community teams;

"80 "sub-acute" beds, where patients need to be treated in an existing community hospital bed, with enhanced home care support." (p71)

However the same plan, on the same page, also proposed to ***cut*** 87 community hospital beds – reducing LPT from 660 beds to 573 (p71). The plan's authors hoped patients could be looked after ***in their own homes***, by miraculous means:

"Services will be expanded **to enable patients to be cared for in their own homes** (equivalent to 250 beds worth of current activity, 170 direct from the current UHL activity and 80 from the existing community hospital activity)." (p90, emphasis added).

Unrealistic

The SOC was unrealistic from the outset. One problem was hugely inflated claims of a massive financial gap. According to SOC projections in 2014:

"The total gap between income and expenditure for the NHS element of the LHSCE [Leicestershire Health and Social Care Economy] in 2018/19 is £398m before any CIP/QIPP or other projects are modelled." (p10)

With a gap that big it was impossible to propose plausible policies to deal with it.

Two years later, in 2016, in an even worse financial situation, NHS England called for Sustainability and Transformation Plans to be drawn up in 44 new "footprints" across England. The LLR footprint plan came up with more bizarre and unexplained statistics and assumptions.

The assumptions underlying this massive, sustained reduction in acute bed numbers at a time of increasing demand for health care were in the realm of fantasy

Despite claiming almost exactly the same spending gap as the SOC two years earlier, the STP outlined a plan to cut a much smaller number (243) acute beds (13%) from a claimed total of 1,940 (p5). This made no sense. Department of Health figures showed a very different total number of beds for that year – just 1,665 (including day care beds). Leicestershire by this measure already had 32 beds fewer than the STP was seeking to cut back to by 2020.

The STP still proposed at the same time to cut community beds by 16% (38). Yet there were no serious plans to establish or resource the "intensive community support" or "integrated teams" envisaged in the STP (p33).

Wishful thinking

It all seemed like wishful thinking. STP reductions for acute and community beds were significantly smaller than the 2014 proposals, but equally unrealistic.

The hopes that diverting large numbers of patients away from A&E and avoiding the need for hospital treatment and thereby allowing hospital beds to be closed have proved unfounded. The pressures on front line services have increased. Only once since the spring of 2017 has UHL even managed to see and treat 90% of A&E patients within 4 hours: most of the time performance has been below 75%, despite the openeng of a brand new A&E facility. Even during the relatively easy winter of 2018/19, waiting times remained abysmal.

Indeed far from being able to close beds and care for patients at home, UHL core acute bed numbers have remained largely unchanged since 2014, with a significant (90%) increase in day only beds: bed occupancy across the relatively mild 2018/19 winter and for most of the year was routinely above 90%, leaving no scope for bed reductions.

Without the bed closures, the huge cash savings hoped for in the STP have not materialised either: the most recent financial report to the UHL trust board shows that it was £31m adrift from its optimistic 2018/19 aim of delivering a £29.9m deficit (which would have resulted in a £0.8m surplus after support payments). This failure resulted in the loss of "provider sustainability funding" – and an end of year situation £50.3m worse than planned.

Campaigners' challenge

One reason local services have remained largely intact has been the consistent challenge by local campaigners. The Campaign Against NHS Privatisation, and newly formed Save Our NHS Leicestershire along with the Leicester Mercury Patients Panel have staged demonstrations, held public meetings, drafted responses, tabled Freedom of Information Act requests, submitted questions, lobbied and briefed local council bodies and MPs.

A hard-hitting critique of the STP by local campaigner Sally Ruane was published by De Montfort University in 2017, and a successful intervention by campaigners later that year effectively derailed plans to move towards setting up an Accountable Care System with no consultation.

In the summer of 2018 campaigners published an even more detailed renewed challenge to plans to relocate Intensive Care (ICU) beds out of Leicester General. The proposal had been pushed through with virtually zero scrutiny and no consultation back in 2015 on the grounds that it was urgent: but three years later it still had not been carried out.

LLR STP's yellow brick road that bears no relation to reality

The reasons for campaigners' concern was that it represented a major first step in downgrading Leicester General, and that it would also disrupt three specialist services for an indefinite period. Vital technical details had not been made publicly available, and even after three years CCGs had still failed to consult the public.

We have already noted the variance between successive plans for bed cuts in acute and community hospital.

How many beds are there?

A campaigners' Briefing Paper for local MP and shadow health secretary Jon Ashworth completed earlier in 2019, notes a new, even higher claimed figure for numbers of UHL beds: 2,045 beds if we believe a Trust response to an FOI request in May 2018, or 1,992 beds according to two trust executives in meetings six months later.

Both of these figures are much higher than official NHS figures for UHL bed numbers, the most recent of which was 1,874 (including 216 day case beds).

Nor is there any consistency on claims for how many patients could be cared for out of hospital: "One UHL spokesman stated 15% of patients currently in UHL beds did not need to be there; another spokesman stated 30% of patients in UHL beds did not need to be there."

Some of these questions might be answered if the Trust, who are seeking £367m to reconfigure their acute services, would only publish a pre-consultation business case (PCBC) which they said last November they were about to send to the NHS investment committee for consideration.

Campaigners have been led to believe the PCBC is a very substantial document (although on previous record, size does not equate to quality). But six months on, despite repeated requests to see and discuss it, it is still being determinedly kept under wraps, allegedly at the urging of NHS England.

More than five years of slipshod planning, secretive processes, evasions of consultation and inconsistent documents give local people in LLR no reason for confidence in the Better Care Together project or the team running it. The longer the PCBC is kept secret the less credibility NHS bosses have with their patients and public.

Campaigners are now calling on local politicians to step up and add their weight to the demand for transparency. Previous schemes drawn up without consultation have proven to be deeply flawed: the danger is that NHS trusts and commissioners are again headed down this same dead end.

"One UHL spokesman stated 15% of patients currently in UHL beds did not need to be there; another spokesman said 30%"

Health tourism: serious problem or tabloid creation?

The Daily Mail and the Express have reported this week that the Government has shelved its plans to crackdown on health tourism, amid accusations that "MPs have caved in to left wing doctors" - so what are the facts?

Pilot schemes have been running at 18 hospitals, introducing charging into some community services, with NHS Trusts having a duty to check the eligibility of all patients before providing treatment in hospital, including many in London.

The schemes, which were begun following an expansion of regulations in October 2017 have now been abandoned after continuous campaigning and complaints about the impact of the policy. Some patients were being asked to pay upfront or risk being turned away.

At the end of April, the Guardian reported on the death of an anti-FGM campaigner and asylum seeker from Gambia, known as Saloum, who was diagnosed with terminal cancer after collapsing in the street last December. Following initial NHS treatment he was sent away because he was not eligible for free NHS care as an undocumented migrant.

However, the charity Doctors of the World, argued that treatment for his cancer was urgent and immediately necessary, which under the regulations should have meant he was treated. Eventually he was given some treatment at the University Hospitals of Derby and Burton NHS foundation trust.

Other stories include a woman with advanced breast cancer denied potentially life-saving therapy for six weeks and one of the Windrush generation, who was denied NHS radiotherapy for six months due to uncertainty over his immigration status.

Campaigns spearheaded by groups such as Docs not Cops have questioned the effectiveness and safety of the pilot schemes. Action by campaigners prompted England's biggest NHS trust, Barts Health, to stop photo ID checks and remove posters warning: 'NHS hospital treatment is not free for everyone.'

What do the figures say?

In May 2018, the Evening Standard reported that figures from London hospitals found that of 8,894 people asked for two forms of ID prior to treatment only 50 actually had to pay for their care.

Media outlets, such as the Daily Mail and The Express, have stated that 'health tourism' costs the NHS £280 million, but there is no reliable evidence to support this figure.

The organisation Full Fact last looked at the figures for health tourism in 2016 and noted that any estimate will be very rough. All the figures used by Full Fact and other organisations come from a 2013 Government report.

The 2013 report estimated that ineligible people cost the NHS almost £2 billion a year, but those that possibly fall into the category of 'health tourist' cost the NHS £100 to £300 million a year or 0.3% of annual health spend.

The report makes it clear that it is extremely difficult to calculate a health tourism figure and that it can only provide a rough estimate. Two reasons why;

- Firstly, it is very difficult to track patients who are not eligible to use the service as no charge is made for GP and emergency services.

The 2013 report estimated that 'health tourists' cost the NHS £100 to £300 million a year or 0.3% of annual NHS spend

- Secondly, there are flows in both directions. The UK creates its own health tourists from people who move to Europe but then come back to the UK to use the NHS, including seeing a GP for repeat prescriptions.

Although the pilot checking schemes seem to have been abandoned, the regulations put in place in the Immigration Act 2014 are still in place. The Act expanded the group of people who can be charged and introduced an 'immigration health surcharge' for those seeking visas to enter the UK, and a charge of up to 150% of the cost of treatment in hospital.

Reaction to the scheme

Groups, such as Docs not Cops and Doctors of the World, say the regulations have created considerable problems - wasting considerable time and money on checking and caused extensive human suffering.

These groups are not alone in condemning the regulations, but despite this at the end of 2018, Secretary of State for Health & Social Care, Matt Hancock stated that "there is no significant evidence that the 2017 amendment regulations have led to overseas visitors being deterred from treatment or that the changes have had an impact on public health".

As a result of his statement in December 2018, the Royal College of Physicians, the Royal College of Paediatrics and Child Health (RCPCH), Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Public Health (FPH) called upon the Department of Health and Social Care (DHSC) to suspend the charging regime (NHS Charges to Overseas Visitors) (Amendment) Regulations 2017, pending a full independent review of their impact.

Docs not Cops and Doctors of the World say the regulations have wasted considerable time and money and caused extensive human suffering

Evidence withheld

The only evidence of the impact of the regulations comes in three reviews conducted for the DHSC: but none of these reports has been made public.

In March 2019, MPs, Royal Medical Colleges, leading academics, healthcare professionals and unions wrote to Matt Hancock, calling for the publication of the three migrant healthcare policy reviews.

These reviews looked at the impact of the controversial policies, including withholding healthcare from migrants who cannot pay in advance. The letter claims the reviews received "evidence of deterrence and serious harm" caused by these policies "which we consider to be of the utmost seriousness".

In an effort to help migrants and other groups caught in the confusion of the regulations, at the beginning of May, the organisations Docs not Cops, Medact and Migrants Organise, launched Patients Not Passports, an online toolkit "to support individuals to advocate for people who face towering advanced payments ahead of accessing NHS care, and to end immigration checks on those suspected of being "overseas visitors"".

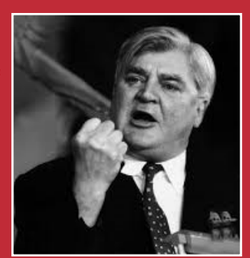
The toolkit contains resources, such as who exactly is exempt from charges and aims to help end the confusion surrounding the regulations, which has led to delays to treatment.

Over the past year or so there have been numerous media reports of delays in NHS care for cancer patients in particular. Although few in the UK are affected by the regulations, as the organisation Docs not Cops notes, they could have a huge impact on us all and on overall public health; if people with infectious diseases are too scared to visit GPs due to irregular immigration status then this could be serious for society. They may wait until the disease worsens leading to much bigger problems in the long run.

Docs not Cops says the regulations represent a complete dismantling of the NHS' founding ideals that "it be based on clinical need, not ability to pay."

What Aneurin Bevan said about health tourism

(from In Place of Fear, 1952)



"One of the consequences of the universality of the British Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes.

No doubt a little of this objection is still based on the confusion about contributions to which I have referred. The fact is, of course, that visitors to Britain subscribe to the national revenues as soon as they start consuming certain commodities, drink and tobacco for example, and entertainment. They make no direct contribution to the cost of the Health Service any more than does a British citizen.

However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors?

For if the sheep are to be separated from the goats both must be classified. What began as an attempt to keep the Health Service for ourselves would end by being a nuisance to everybody.

Happily, this is one of those occasions when generosity and convenience march together.

The cost of looking after the visitor who falls ill cannot amount to more than a negligible fraction of £399,000,000, the total cost of the Health Service. It is not difficult to arrive at an approximate estimate. All we have to do is look up the number of visitors to Great Britain during one year and assume they would make the same use of the Health Service as a similar number of Britishers. Divide the total cost of the Service by the population and you get the answer.

I had the estimate taken out and it amounted to about £200,000 a year. Obviously this is an overestimate because people who go for holidays are not likely to need a doctor's attention as much as others. However, there it is. for what it is worth and you will see it does not justify the fuss that has been made about it.

The whole agitation has a nasty taste. Instead of rejoicing at the opportunity to practice a civilized principle, Conservatives have tried to exploit the most disreputable emotions in this among many other attempts to discredit socialized medicine.

Naturally when Britons go abroad they are incensed because they are not similarly treated if they need the attention of a doctor. But that also I am convinced will come when other nations follow our example and have health services of their own."

What the (research) papers say

Lessons from last winter's crisis

John Lister

This recent BMA overview of the experiences, performance and lessons from the winter pressures on the NHS in 2018-19 is a valuable and readable resource accessible to all, although it only focuses on acute care and does not discuss equivalent pressures on mental health.

Just 22 pages long, NHS Pressures – Winter 2018/19 A hidden crisis collates a very useful range of information sources in its bibliography at the end, and breaks the winter crisis down into bite sized and easily recognised chunks.

Perhaps even more important an overview final section 'How can we relieve pressure on the NHS?' sets out a series of positive proposals for doctors, trade unionists and campaigners to take up with MPs and with national and local NHS chiefs.

One notable feature from the outset is the significant (6%) increase in demand for emergency care despite almost three decades of assurances and assumptions by ministers and NHS chiefs that it would be reduced by alternative services outside hospital.

The study makes clear the inadequate number of beds: average bed occupancy this winter was 93.5%, and 41 trusts (of 134) recorded bed occupancy of 100% on at least one day.

Despite clear calls from the Royal College of Emergency Medicine and the BMA last winter for more beds to be brought on stream, the total number of beds across NHS England was consistently down on last year's numbers.

Cancer care was also delayed in most trusts, with almost 70% of providers missing the target for 85% to be treated within 62 days of referral in both January and February.

Although there is no comparable level of detailed data on primary care the report shows GP appointments involving a wait of over two weeks were up 13% on last year.

The conclusions highlight under-funding ("health spending in the UK would have to be increased by £9.3bn for the year 2019/20 in order just to draw level to the EU countries' average health spend of 10.1% of GDP"] the need for more beds and for improved data all year round on beds and much more data on primary care.

The paper does what it says on the cover: it may have surprisingly little to say on staffing, and it is not by any means a full manifesto for change, but it does bring together the data we can use to compare further winters to come.

THE lowdown

Health news, analysis and campaigns.
NUMBER 3, May 25 2019

Informing, alerting and empowering NHS staff and campaigners

Circle's defeat hailed as a victory by campaigners

A crowd of campaigners rallied outside the High Court's Rolls Building on May 15 to express their support for the decision to end 11 years of privatisation and allocate a major treatment centre contract to Nottingham University Hospitals Trust rather than private hospital firm Circle [as we headlined in our last issue].

Within a week of the hearing the news emerged that the NHS had won, and Circle's case had failed.

The campaigners had responded to calls from Keep our NHS Public in Nottingham, UNISON's NUH branch and Unite activists in Nottingham who had campaigned to get Circle's contract, yielding £2.9m a year of profit, ended.

They has welcomed the decision when it was finally made by a consortium of 16 CCGs in the East Midlands and Yorkshire led by Rushcliffe CCG, and endorsed by NHS England's Regional Director.

But celebrations will be muted until a further threat of legal action by Circle, seeking damages from the CCGs, has been dealt with later this year.

Background: see inside, page 2

Harlow hospital staff announce six days of strikes to stop privatisation

Backed by an overwhelming 99% majority vote of almost 84% of UNISON members voting and by the other unions at the hospital, domestics employed by Princess Alexandra Hospital Trust in Harlow have announced six days of strikes against their service being subjected to market testing.

The strikes will begin with a single day on June 6, the date of the next Trust board meeting, with further strikes if the Trust does not see sense on 11-12 June and 18-20 June Campaigners are urged to support by signing the petition and donating to the strike fund.

The domestic staff warn that if their services were to be transferred into the private sector it would spell 'disaster' for their patients.

Princess Alexandra Hospital currently has one of the lowest rates of infection in England, including instances of MRSA. By contrast cleaners from the hospital have recalled the brief privatisation of services in the 1990s, when Mediguard had to hand back the contract after just one year because of its failure to maintain standards.

The strikes will begin with a single day on June 6, the date of the next Trust board meeting

It's almost exactly 35 years since Margaret Thatcher's government triggered the first strikes by hospital domestics against the imposition of competitive tendering for NHS support service contracts. Widespread privatisation resulted in a massive deterioration in hospital hygiene standards as trusts were forced to accept the lowest bid regardless of quality concerns.

Twenty years later, in 2004 the Department of Health belatedly drew the link between compulsory competitive tendering and declining standards of hygiene and support services. Some have still not learned the lesson: recent research found that private contactors were still delivering services to English trusts, and were "cheaper but dirtier than their inhouse counterparts."

Princess Alexandra staff also warn that their pay and conditions will fall below their NHS colleagues if their services are outsourced, because a private company would not be part of any future NHS pay awards, and new starters could face substantially worse employment terms.

IN THIS ISSUE

Circle's hopes are dashed by High Court

(From front page, top story)

John Lister

Circle Health has been fighting since the beginning of last year to cling on to the contract to deliver services from the Nottingham Treatment Centre. The contract was worth £55m in 2017 (and brought a profit of £2.9m).

Circle has run the centre since the first contract was first offered by New Labour back 2008 - a time when NHS trusts were barred from competing.

The company secured another five-year deal in 2013, but by 2018 the rules had changed, and NHS trusts are now allowed to bid to bring back in-house and re-integrate services that were arbitrarily privatised by the establishment of treatment centres.

Cash-strapped CCGs are lso increasingly looking to cut costs.

Last year Circle complained at the reduced money on offer, which it claimed was insufficient to ensure adequate services at the centre, pulled out of bidding and threatened legal action. These antics secured a further year's extension of contract, but did little to win over the CCGs.

In January this year Circle Nottingham asked the High Court to stop NUH taking over the contract.

Their argument was made no more convincing by Circle apparently inflating the value of the previous 5-year contract, which it insisted had been worth £67m a year, although Circle Nottingham's own accounts show their income has hovered around the £55m mark for the last couple of years.

Since then NUH has become the CCGs' preferred bidder for a new £64m a-year contract, while Circle complains the five-year deal has been unfairly awarded to the Trust and breaches competition law.

In what can be seen in a heavily redacted court document, Circle claimed NUH could not credibly deliver what it estimated to be 16 percent savings on current costs, without impacting patient services.

The private-equity-owned company, which depends upon NHS funding and has never posted an overall profit and notoriously walked away from its failing contract to run Hinchingbrooke Hospital just two years into a 10-year contract, has the brass neck to point to NUH's £30m operational deficit and question its financial viability, arguing the trust would need to rely on government loans, and that this would breach competition law.

Circle must now face up to having lost their largest NHS contract (and one of very few making any profit.)

Circle also argued that NUH's staff costs would be up to 20 percent higher than its own. That's no surprise, since the Nottingham Treatment Centre employs less than one in 10 (just 12) of the consultants who work there, and is heavily dependent upon another 163 NHS-employed consultants with "practising privileges" to do occasional private sessions. Delivering only limited, elective surgery, Circle has never had to carry the costs of emergency and complex cases – all of whom are treated at NUH.

Despite employing all these arguments, this time Circle were not so fortunate in their resort to legal action. Deputy High Court judge Sir Anthony Edwards-Stuart ruled that the CCGs could go ahead and hand the 5-year £320m contract over to NUH from July.

The Nottingham unit, on the QMC site is Europe's biggest treatment centre, and provides NHS-funded services including gynaecology, cardiology and respiratory medicine.

The company must now face up to having lost their largest NHS contract (and one of very few, if not the only one of their contracts making any profit.) Having delayed matters by months before losing their court action Circle has now argung the timescale is too tight for the handover to be achieved in time for a July start.

However *BMA News* last year reported that Nottingham University Hospitals Trust (NUH) which had spent at least £500,000 drawing up its bid to bring the treatment centre in-house, and noted that the move would see patient care much less fragmented in the city.

Now the Trust will be able to make efficiency savings by reintegrating the services, most of which it has had to run in parallel in order to deal with cases too complex for a treatment centre to handle. It would of course also gain a significant extra injection of revenue to cover its extra costs.

The Trust and commissioners now clearly see the benefit in NUH receiving the extra revenue, rather than Circle and its owners.

However we have not heard the last from Circle on this disputed contract. They are still saying they will sue the commissioners for damages from what they say is an "unfair" procurement.

What are the chances the High Court will follow up its judgment in favour of the NHS by suddenly deciding the procurement process they have just endorsed was flawed, and awarding damages to Circle?

Who knows what another judge on another day might decide? Campaigners will need to remain vigilant until the further hearing has taken place later this year.

Private hospital at risk

The even worse news for Circle is that the outcome of the case must also leave the future of its private hospital on the Queens Medical Centre site in doubt, now the building will be taken over by the NHS.NHS patients are not allowed in to it.

Circle had been exploiting the proximity to the NHS to lend prestige and credibility to its range of surgical and diagnostic services for self-pay and insured patients – with eye-watering minimum fees of £12,250 for a knee replacement, £2,265 for an inguinal hernia repair and £2,246 for a cataract operation.

GP At Hand: more questions than answers

The long-awaited and repeatedly-postponed report on Babylon GP At Hand service has finally been published – but anyone hoping for clear answers to clear questions will be disappointed.

The report does confirm suspicions that GP At Hand has predominantly recruited younger, fitter, more affluent patients.

It therefore implicitly concedes that by allocating enhanced resources to them the NHS has effectively drained resources from care of more vulnerable patients and older people with great and more complex health needs.

94% patients enrolled with BGPaH are aged 45 or under, and two thirds of them live in more affluent areas.

Surprisingly this relatively youthful, wealthy and healthy patient cohort is actually also more likely than the average to make use of primary care, 111 and A&E services.

However (p80): "even if additional demand for primary or secondary care services had been observed in BGPaH patients, no conclusions could have been drawn on whether this demand was an appropriate use of healthcare resources."

There are so many other conclusions that also cannot be drawn, according to the 93-page report. It repeatedly calls for further research and investigation.

Among the key issues fudged is the key question of the cost-effectiveness of the model (which cannot be assessed "due to the absence of data on patient outcomes" (effectiveness) – but also a lack of any information or transparency on the costs of the model.

"For commercial sensitivity reasons, no data are available on the costs of maintaining the bank of GPs or the infrastructure development by Babylon."

The report does argue that it could still be cost-effective for the NHS to spend additional money on the BGPaH model … "if the outcomes for patients are sufficiently better than through traditional practice."

But are the outcomes better?

"The evaluation team do not know if this is the case because data on patient presenting problems or outcomes was not available…"

Debt ridden STP shakes a collecting tin

John Lister

It's not that unusual to see large deficits in today's NHS, after almost a decade of brutal austerity limits on funding, but the deficits are so large in the East of England that NHS England/ Improvement's Regional Director is passing round the hat round to five STPs, pressing them each to 'lend' £5m to the sixth, the floundering Cambridgeshire and Peterborough STP.

This has caused some bitter resentment, not least in Norfolk where the press reported an angry lay member of North Norfolk CCG, Peter Franzen, responding sharply to the request for a £5m handout to prop up budgets elsewhere:

"Can I ask how we think the public would feel about another £4-£5m of cuts to a system that's already in debt and being asked to make savings to help another system?"

The extra £25m is barely a drop in the ocean of red ink that has covered the accounts in Cambridgeshire and Peterborough for the fast four years (with end of year deficits in excess of £100m each year since 2015). According to the latest STP Board papers "the underlying exit position for 2018/19 going into 2019/20 was [a deficit of] £212m."

Remarkably even this level of deficit still meant the STP was eligible for £52m of "Provider/ Commissioner Sustainability Funding" (which used to be restricted to trusts that achieved their targets), bringing the C&P "final system outturn" to a deficit of £148m.

Cambridgeshire and Peterborough health bosses are now focused on the huge challenge for 2019/20:

"Over the past few months, System partners have been developing their financial plans for 2019/20, with a System Control Total set of £142m overspend."

Once again the three acute trusts and the CCG have rejected their control totals; their response seems almost surreal:

"Our latest plan is an overspend of £192.4m; this is still £50m away from the System control total but will, subject to the agreement of our regulators, enable us to access a substantial sum of £80.6m of Provider/ Commissioner Sustainability Funding (PSF/CSF) available to this System for those organisations achieving their respective Control Total."

"Our latest plan is an overspend of £192.4m; this is still £50m away from the System control total …"

This is the £192m deficit towards which the other five STPs have now been asked for loans – bringing the deficit down to a mere £167m – and halving the gap from the control total set by NHS Improvement.

Ironically however, Norfolk and Waveney STP which has been press ganged into becoming a grudging donor to this support fund, is itself facing some punitive savings targets in the effort to squeeze their combined deficit down to £16.5m this year, and thereby secure almost £70m of 'sustainability funding'.

The omens are not good: the STP has three major trusts in special measures, and was expected to wind up with a combined deficit of £96m for 2018/19, despite delivering £104m of 'efficiency savings'.

The largest acute trust, Norfolk & Norwich University Hospitals alone ended 2018/19 with a £58.8m deficit, more than £6m worse than planned.

The STP drawn up in 2016 aimed to save £300m by 2021, and expected the system to be £4.5m in surplus by 2018/19. Former New Labour Health Minister Patricia Hewitt who now chairs the STP has admitted the plan was "over optimistic".

But with control totals being wilfully ignored, and huge deficits concealed year after year by handouts of sustainability funding for fear of the consequences of imposing truly massive cuts, it is clear that Regional Director Ann Radmore is deep in denial, claiming against all the evidence that:

"We expect every NHS organisation to live within their means, and the benefit of taking a joined-up regional approach is that we can tackle the issues together."

Her region is set for an overall shortfall this year of £76m: all the covert subsidies, handouts and loans can't hide the fact that the NHS in eastern England – and every other area – is drastically underfunded.

Concordia sheds NHS dermatology contract at short notice

Concordia Specialist Care Services gave just five days notice for the termination of its contract to provide dermatology services to patients in North East Essex earlier this month. The company has now left the contract two months before its end date of July 2019.

No formal reason has been given for leaving the contract, although it is known that the company is restructuring. The contract began in July 2017 and was for five years, but this was reduced to two years by North East Essex CCG last October.

The service provided by Concordia was criticised in a critical CCG report, after team inspected Fryatt Hospital, the base for the Concordia service, in mid 2018.

The CCG report noted: "Standards of hygiene and cleanliness in a number of areas did not comply with national standards, medication was out of date, specimens were inappropriately stored in a medication fridge and Concordia staff were unaware of how to access organisational policies."

The service has been taken over by East Suffolk and North Essex FT and the service's six staff have been transferred to the trust.

An article in the HSJ suggested that the parent company Omnes Healthcare LLP (known as Concordia Health LLP until last week) has financial difficulties, but the company has denied this and says it is restructuring and no other service is affected.

Omnes Healthcare LLP operates under a number of subsidiary names, but primarily Community Outpatients Ltd and Concordia Specialist Care Services Ltd.

The company's Community Outpatients website states it works for over 40 CCGs at over 150 community sites and lists dermatology, ENT, cardiology and endoscopy as services provided.

Concordia is not the first private company to abandon a contract leaving the local NHS services to pick up the work. Earlier this month we reported on Virgin Care terminating part of its contract in East Staffordshire for services for the frail and elderly.

The part of the contract covering the sub-contracting of various services has now moved back to East Staffordshire CCG. This was followed by Virgin Care announcing that it is terminating the entire contract three years early in 2020, arguing that the reason was a failure to come to a financial agreement with the CCG.

"My patient records are missing!"- Capita may know why

Sylvia Davidson

This week it emerged that Capita has wrongly archived 130,000 patient records rather than sending them on to the GPs of newly registered patients. This is the latest in a long chain of failures in its contract to carry out Primary Care Support (PCS) services.

NHS England has stated that there is no evidence of any harm due to the error, but the BMA countered that this judgement was based on only a looking at a small number of records and "the blunder typified the problems that had beset the service since Capita was given the contract."

In 2018, it was found that Capita had failed to send letters to almost 50,000 patients on the cervical cancer screening programme.

As a result, in March 2019, NHS England decided to take the cervical screening programme back in house away from Capita.

An earlier investigation into the contract by the Public Accounts Committee concluded that errors by the company had "potentially... put patients at risk of serious harm" as thousands of GPs, dentists and opticians had been delayed in treating patients.

- A profile of Capita
- Support our campaigning journalism

In July 2018 Capita claimed the problems had been ironed out and NHS England said the contract was delivering savings.

In comments to this week report in the BMJ Richard Vautrey, chair of the BMA's General Practitioners Committee, said, "Capita has consistently proved itself unfit to hold this contract.

NHS England has at last listened to the BMA and now plans to bring cervical smear administration back in house. And with this latest blunder they now must urgently do the same for all of these services."

Capita took over the coordination of primary care support services in September 2015. The contract with NHS England was designed to save £40 million per year by bringing together a previously fragmented service to a single national provider for Primary Care Support England (PCSE).

Capita's bid hinged on making a £21 million per year saving. The contract is worth £330 million over seven years.

Capita immediately began centralising support services to three national hubs and implementing a single online 'portal' for practices to order supplies and 'track' the movement of patient records.

However, since the contract began there has been an never-ending series of problems - ranging from things as mundane as surgeries running out of prescription pads and syringes to far more serious problems with the secure transfer of patient notes around the country, with notes going missing or delivered to the wrong surgery, and women being dropped from the cervical cancer screening programme.

The problems encompassed GPs, dentists, opticians and pharmacists.

A campaign by the GPC (General Practice Council) has been ongoing since early 2016.

Determined strikes at Wrightington, Wigan and Leigh defeated management plans to outsource staff to a new "wholly-owned company" – and appear to have set a new tone of militant resistance by health unions against privatisation and contractors

Fighting privatisation – far from a lost cause

How far has the process of privatisation already gone within the NHS: and how much further is it set to go, given the constraints on funding and political considerations? In this 4-page feature JOHN LISTER takes an in-depth look at the facts.

Earlier this year, in the aftermath of the NHS Long Term Plan, NHS England opened up a discussion of proposals to change or remove sections of the 2012 Health and Social Care Act, notably to remove the requirement on Clinical Commissioning Groups to carve up services and put them out to competitive tender.

There was a distinct change in the language used, as NHS England sought to persuade unions, campaigners and politicians that their agenda was one of "integration", replacing competition between public and private sector for contracts with collaboration and cooperation.

The response has been mixed, with some even dismissing the proposals as a covert, if convoluted, route to further privatisation ("This legal change will not halt the privatisation of the NHS, it will accomplish it!").

Many campaigners have understandably found it difficult to understand the contradictory role of NHS England, which was on the one hand vigorously driving forward with new privatisation initiatives while at the same time professing frustration with the law they were implementing.

The Lowdown has carried numerous reports on the new inroads being made by the private sector into NHS budgets, notably the moves to establish new multi-£billion pathology networks in which private sector providers will be leading or prominent components of consortia, and imaging networks, which are likely to follow the model of the controversial privatised contract for PET-CT scanning in Oxfordshire.

The value of contracts subject to competitive tendering as a percentage of CCG spending on clinical services fell by a third (from 3% to just 2%) between 2015 and 2018

In our last issue we reported plans to include private healthcare companies in decision-making on the allocation of NHS mental health budgets totalling over £2 billion, and (unsuccessful) attempts to involve a large number of private providers in an innovative plan for Child and Adolescent Mental Health services in Kent, Surrey and Sussex.

Some critics and campaigners conclude from these and other manifestations of privatisation that the path leads inexorably to much wider extension of privatisation, with talk of "endgame," and some arguing that NHS England's plans are leading towards a US-style system, complete with US health corporations, charges for care and private insurance.

However it's clear that the private sector sees the situation very differently.

Circle Nottingham management are licking their wounds and counting the cost of their failed legal challenge to the loss of their most lucrative NHS contract – and they are by no means the only private providers who are arguing that the system is increasingly "unfair" and making life difficult for them.

Private sector response

Responding to the NHS England proposals for legislative changes, the Independent Healthcare Providers Network argued that from their point of view they do not want an American-style system based on private health insurance ("The NHS remains and in our view should continue to remain publicly funded and free at the point of use").

Indeed they realise that with most of the people in most need for health care also being those least likely to be able to pay a market price for it or secure health insurance, only government funding can pay for many of the contracts and episodes of care that keep the private sector, and especially private hospitals, afloat.

But the IHPN also went on to attack the "myth" that the NHS is being privatised.

The IHPN began by pointing to their own findings

from Freedom of Information requests to England's CCGs which showed the proportion of NHS contracts awarded through competitive tendering has fallen in recent years, from 12% of all contracts in 2015/16 to 6% the following year, before recovering partly to 9% in 2017/18.

The value of these contracts as a percentage of CCG spending on clinical services has fallen by a third, from 3% to just 2% over the same period.

This is consistent with previous findings from NHS Providers that the private sector has been most successful in winning community health services contracts, with many more contracts than the NHS, but that most of these are small in value, leaving NHS trusts with just 21% of contracts, but 53% of the contracts by value compared with just 5% for the private sector.

Department of Health and Social Care Annual Report figures show the amount spent by the NHS on private providers of clinical services rising each year from 2006, from just over £2 billion to almost £9 billion by 2016, and the private sector share of NHS spending rising from 2.8% to 7.7% over the same period.

However this flat-lined in 2016/17, and declined to £8.7 billion (7.3%) in 2017/18.

Contracting by trusts

The Department annual figures are for CCG spending only, and do not include the contracting out of services by NHS and foundation trusts, so they significantly understate the scale of private sector involvement in the NHS.

Recent research, looking at NHS data for 130 hospital trusts from 2010 to 2014 found that an average

An average of around 40% of hospital trusts still had contracted out cleaning services in 2014, suggesting this service alone was costing around £500m per year.

of around 40% of hospital trusts had contracted out their cleaning services, at an average cost of £3.84m per trust (although there is wide variation) – suggesting this service alone was costing an additional £500m per year five years ago.

We know many other support services have since the 1980s been contracted out to private companies – catering, laundry, security, car parking, patient transport: these too are additional to the DHSC Annual Report figures.

In some areas clinical support services have also been contracted out by trusts, increasing even further the role of the private sector.

Contracts for clinical care

In terms of clinical care, the BMA late last year found that 44% of NHS private spending was on community health services, 25% on general and acute services and 11% on mental health.

The BMA's online report included a useful breakdown of the top 12 private firms, identifying the number of contracts awarded to private providers by the 73 CCGs that responded to FoI requests.

This showed the private acute hospital chains holding the largest numbers of contracts over £50,000, with Spire (52) and BMI (49) followed by Ramsay (28)

44% of NHS private spending was on community health services, 25% on general and acute services and 11 % on mental health

and Nuffield Health (26) together making up more than half the total of 287.

The private hospitals have been keen to cash in on the under-funding and lack of capacity of NHS acute trusts after nine years of reductions in front line beds while the population and pressure on services has increased. Even prestigious teaching hospitals such as King's College hospital in London have been driven to outsource elective care to private hospitals.

As a result, according to the IHPN "elective care is critically dependent on independent sector provision". However this seems to be an exaggeration, to judge from the IHPN's own claim that around 6% of NHS elective admissions are now going to private hospitals. This leaves leaving the NHS to deal with the other 94% – as well as 100% of the emergencies, complex and chronic care.

There is little scope for a major rapid expansion of the private acute hospitals themselves. With a few exceptions the hospitals tend to be very small, averaging just 46 beds, and focused entirely on quick turnover elective treatment. And while private hospital bosses would prefer to be able to fill beds with self-pay and privately insured patients who pay higher fees, there are not enough of these patients around.

So private hospitals have become dependent upon NHS-funded patients (and self-pay patients driven by despair or chronic pain to leapfrog growing NHS waiting lists) to fill otherwise empty beds.

Of course they also depend upon NHS-trained and often NHS-employed medical and nursing staff to deliver treatment and care.

Gloomy view

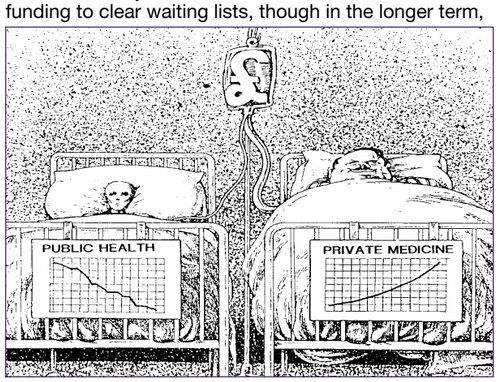
Far from the private sector feeling chipper and anticipating good times ahead, a recent IHPN blog indicates a much less positive mood:

"Private healthcare finds itself at a crunch point. Low (or no) growth across local and international markets, spiralling costs, falling medical insurance subscriptions and "intelligent consumerism" continue to challenge the sector."

This follows on a downbeat assessment of the prospects for private hospitals from market analysts Laing & Buisson in 2018:

"a number of providers face clear challenges. Notably, those which have a heavy reliance on NHS as a customer have faced some market disrupters recently, as growth has grounded.

"Growth may return when the NHS uses additional funding to clear waiting lists, though in the longer term,



Mental health: stronghold of private provision

The NHS reliance on private providers can be much greater in mental health services.

Department of Health figures compiled by the Nuffield Trust showed a massive 24% of mental health spending went to non-NHS providers in 2012/13, and that private provision was growing at the expense of the NHS:

"funding for independent sector mental health service providers increased by 15 per cent in real terms between 2011/12 and 2012/13 alone, while funding for NHS-provided mental health services decreased by 1 per cent". (page 6)

Laing & Buisson estimate 30% of mental health hospital capacity is now in the private sector, and revenue is increasing. A report early in 2018 notes:

"robust revenue growth for independent mental health hospitals in recent years, amounting to 12% in 2015 and

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4% in 2016, though pressure on prices by financially stretched NHS agencies has meant some diminution in profit margins. […]

"… the main driver continues to be the long-term trend towards NHS outsourcing of non-generic mental health hospital treatment, which shows no sign of abating. CCG block contracts with NHS Mental Health Trusts, which give the Trusts little incentive to expand their own in-patient capacity or even maintain what they have, limited NHS capital budgets, and risk averse behaviour of Trusts all contribute to the growth in demand for independent acute mental health bed capacity."

However the imbalance is even more dramatic in child and adolescent mental health: recent reports reveal that no less than 44% of the £355m NHS spending on CAMHS care goes to private providers, and figures given in parliament last November again show how the private sector spend has grown by 27% over 5 years from £122m to £156m, although spending on NHS providers has risen faster (by 40%).

In mental health the private sector domination is most complete in the provision of "locked ward rehabilitation", in which a massive 97% of a £304m market in 2015 was held by private companies

The private sector domination is most complete in the provision of "locked rehabilitation wards", in which a massive 97% of a £304m market in 2015 was held by private companies, the largest of which was the (now merged) Cygnet/Cambian (20-30%), with substantial involvement also of Acadia (Priory Group) with 10-20% and Huntercombe with 5-10%.

The merged Cygnet in 2017 reported operating 2,400 beds across 100 sites, with over 6,000 staff. In the summer of 2018 it also took over the Danshell Group, operating 25 units with 288 beds for adults with learning difficulties. While Cygnet Health Care recorded a loss of £9.4m on turnover of £121m in 2017, the Group reported a very healthy profit of £40m on turnover of £334m.

The increased proportional spend on private providers has made them even more dependent on funding from the NHS to prop up their balance sheets: the most recent accounts of the largest mental health provider, the Priory Group, show that 52% of its income of almost £800m came from the NHS, and another 38% from social care – a total of 90%.

According to the Competition and Markets Authority the market for mental health services was worth a total of £15.9 billion in 2015, 27% of which was for hospital services, and the private hospital sector had grown by 8% in the previous five years, while NHS capacity had been cut by 23%.

market fortunes in this area are difficult to predict."

Another problem faced by would-be private providers of NHS services is that the near-decade of austerity ushered in by David Cameron's government and maintained ever since has meant that many of the contracts that have been offered up for tender have been under-funded.

As a result several private bids have been withdrawn prior to the contracts being awarded leaving only NHS bids on the table, or companies have not even bid at all, or in some cases simply walked away from contracts that were incurring or threatening them with losses.

This happened at Hinchingbrooke Hospital, and with many patient transport services, and contracts in community and primary care.

Virgin recently revealed it will walk away from an underfunded community contract in East Staffordshire, and Concordia's last minute notice of withdrawal from a dermatology contract in Essex (see page 4).

Many of the large-scale Integrated Provider Contracts that campaigners (despite the assurances of NHS England) fear could be opened up for the private sector seem certain to include the more costly, risky and less profitable services that the private sector has always been careful to avoid.

It seems likely any private sector involvement in IPCs or Integrated Care Systems will centre on specific tasks with guaranteed profitable prospects – such as so-called "backroom" services

Targeting potential profit

With this danger in mind it seems likely any private sector involvement in IPCs or Integrated Care Systems will centre on specific tasks with guaranteed profitable prospects – such as so-called "backroom" services handling data, managing processes, drawing up specifications, along the lines tried and tested by UnitedHealth subsidiary Optum in England and in the US; or supplying apps and other IT expertise and equipment; or clinical support such as pathology and imaging contracts.

It's important to remember that private health providers are not in it to make a point, but to make a profit. They don't like risk, and Virgin in particular has seen that 'loss leader' contracts tend to go on not to more profitable contracts but to large losses, or even services being brought back in house.

So while we fight on to resist every further encroachment of the private sector, and aim to roll back the privatisation that has taken place, it's clear that we have a lot of NHS still to defend, and the private sector are far from content with the position they are in.

The increasing combativity of health unions mobilising NHS staff to resist outsourcing of services to "wholly owned companies" – with some successes already achieved – and with contractors' staff currently waging campaigns including strikes to secure parity of pay with NHS staff – there is a strong basis for unions, campaigners and supportive politicians to challenge any and every further attempt to erode our NHS.

● ***The Lowdown*** will take a further more in depth and historical view of privatisation in future issues.

Where does all the "non-NHS" money go in Greater Manchester?

Caroline Bedale

Using private companies to deliver NHS services means taxpayers' money is being used to pay for profits to directors and shareholders.

Since 2013 decisions on commissioning have been in the hands of Clinical Commissioning Groups (CCGs). These have been required by the 2012 Health and Social Care Act to put an increasing range of services out to tender, but in many cases they have been eager to privatise services.

A report by the NHS Support Federation in December 2017 found CCG spending an average of 15% of their commissioning budgets on 'non-NHS providers' – private companies and charities.

Nor is the problem resolved by use of "non-profit" providers. Large voluntary sector and charity organisations provide a lot of NHS services – and while they don't make profits or pay dividends to shareholders, their involvement in providing services means that that funding is taken away from the NHS itself and services are fragmented between many providers.

The voluntary/charitable sector should have an important role to play in making sure disadvantaged groups have a big say in their healthcare and in lobbying for better services: but they should not be providing mainstream NHS healthcare services.

There is also a significant difference between the relatively small amounts paid to local voluntary/charitable sector organisations and much larger amounts to regional/national ones.

Despite devolution in Greater Manchester, where all the councils (which supposedly should as a result have a say over the decisions on NHS plans) are now run by Labour, the private sector and large voluntary/charitable sector still hold contracts for many healthcare services.

Spending on main private providers (over £400,000 total) in Greater Manchester 2017-18

District	Total Healthcare expenditure (£)	Total expenditure on non-public providers (£)	Percentage non-public of total healthcare expenditure
Bolton	353,982,000	44,653,000	12.6
Bury	217,709,000	24,982,000	11.5
Manchester	690,446,000	87,660,000	12.7
Oldham	276,537,000	50,397,000	18.2
Rochdale	273,153,000	39,082,000	14.3
Salford	340,389,000	33,762,591	9.9
Stockport	347,197,000	37,659,000	10.8
Tameside	284,943,000	31,546,560	11.1
Trafford	274,343,000	29,659,853	10.8
Wigan	394,083,000	39,346,603	9.9
Total	**3,452,782,000**	**418,748,607**	**12.1**

Private Hospitals and Surgery – General and Acute		Spending (£)
BMI Healthcare – Alexandra		30,157,822
Ramsay Healthcare		16,098,548
Euxton Hall, Chorley	1,633,995	
Oaklands, Salford	13,713,158	
Neurological Services	526,020	
General	225,375	
Pennine MSK *musculoskeletal*		7,103,770
SpaMedica *eye surgery, cataracts*		6,484,729
Optegra *private eye hospital*		4,408,446
Spire Hospital		2,686,777
Fairfield Independent Hospital, St Helens		2,677,914
Care UK Clinical Services		2,179,294
Manchester Surgical		1,401,726
Marie Stopes International *abortion, IVF*		1,250,790
Beacon Medical Services Ltd *minor surgery*, ENT		1,177,441
Pregnancy Advisory Service /		2,356,850
Total (General and acute)		**77,984,107**

Diagnostic / Assessment / CATS	Spending (£)
InHealth	7,707,861
(inc InHealth Pain Management Solutions £677,854)	
Lancaster House Consulting & Diagnostic & Surgical Ltd.	5,327,000
Mediscan Diagnostic Services	2,141,464
Alliance Medical *diagnostic & molecular imaging*	1,686,391
Durnford Dermatology CATS	1,088,000
Diagnostic Healthcare	841,375
Total diagnostic/CATS	**18,792,091**

Private Hospitals – Mental Health, other mental health services and learning difficulties	Spending (£)
Priory Group, Cheadle Royal	4,784,329
HC-One	3,641,387
Alternative Futures	3,558,270
Cygnet (Universal Health Services)	3,386,621
Cambian Care/Care Tech	3,224,089
Turning Point	3,194,876
Big Life Services/Big Life Co	3,090,088
Self Help Services	2,557,862
Making Space	2,380,279
Elysium Healthcare	2,295,740
Equilibrium Healthcare	2,074,686
Six Degrees	1,490,859
Partnerships in Care	1,272,933
Mind (Manchester, Tameside & Gl)	1,225,754
John Munroe Group Ltd	1,162,903
Transitional Rehab Unit	974,271
Total (mental health and LD)	**40,314,947**

Community Services	Spending (£)
Virgin Care Providers Services Ltd	1,939,268
sexual health (Oldham Public Health)	1,100,000
Turning Point	2,500,000
Specsavers Hearcare	2,345,086
ABL Health	1,501,188
IntraHealth	1,040,476
Totals community services	**10,426,018**

The main private sector providers of CCG-commissioned NHS services with contracts adding up to £1m (or close to it) in Manchester in 2017/18. Total (higher) figures for non-NHS spending will include local government.

Local campaigners wanting to get a full picture of where public money was being spent made Freedom of Information requests to all the 10 Clinical Commissioning Groups in Greater Manchester (CCGs control the funding for most NHS services), asking for expenditure on services from non-NHS / non-public sector organisations in 2017/18.

This revealed a near 100% variation in the percentage of CCG spending flowing to non-NHS providers, with a lowest figure of 9.9% (Wigan and Salford) and a highest of 18.2% in Oldham. Overall the average was 12.1%, equivalent to almost one pound in every eight going outside the NHS.

The collated data also reveals the major players among the private providers, with the private acute hospital chain BMI Healthcare the biggest winner, with contracts totalling over £30m, followed by Ramsay Healthcare which picked up over £16m of contracts, the largest share of which went to its Salford hospital, Oaklands.

Two other private general and acute providers, Pennine MSK and Spa Medica (eye surgery and cataracts) were also well ahead of a list of 12 companies or charities gaining more than £1m contract income from Greater Manchester CCGs.

Among the mental health providers, Priory Group (owners of Ticehurst House in East Sussex, where severe failures of care were recently exposed) topped the list with almost £4.8m, followed by the less well-known HC-One (which was formed out of the collapse of Southern Cross, and put up for sale last summer, and has just been fined for a failure of care in a Scottish care home) with £3.6m.

However both would have been eclipsed if the subsequent merger of US-owned Cygnet (owners of the Durham hospital Whorlton Hall, recently exposed by BBC's Panorama) with Cambian Care/Care Tech had taken place earlier: each company picked up contracts in excess of £3m, and their combined total would have been £6.6m.

Spending on diagnostic services was heavily dominated by InHealth (a company currently in the news for its involvement in a highly controversial PET-CT scanning contract in Oxfordshire) which picked up a total of £7.7m, ahead of Lancaster House with £5.3m.

By contrast with the other services, the scale of contracts awarded for community and public health services are much smaller.

But with a total of £418m flowing out of the CCGs to private providers in Greater Manchester alone in 2017/18, the obvious question is how much better could NHS services be if they were given this extra revenue, and the capital they require to deliver services: and how long can this scale of private spending continue alongside NHS England claims that they want to "integrate" services?

A note on the data

Three of the CCGs, Bury, Manchester, and Stockport would only give the names of private providers but no financial details – saying that 'commercial sensitivity' prevents them from giving out this information.

Previously, at the start of the financial year, Stockport had supplied a table listing providers, service type, service description and contract values for 2017/18 – but in many cases actual financial amounts were not given on the basis that they were activity based contracts or AQP contracts, or that it was a framework agreement, or cost per case, so there was no specific contract value. In some cases specific figures were given. Figures in in the section on Stockport are those given in that table of contract values for 2017/18.

However, all CCGs have to comply with a government requirement to publish any payments they make over £25,000 each month, so this data has been used to provide some additional information about the private / voluntary sector expenditure in those 3 districts.

There were sometimes discrepancies between the financial information supplied by some CCGs and the figures in their Annual Reports, but these were not major and do not distort the overall picture.

This analysis focuses on expenditure on healthcare services which are not provided by the NHS or other public sector bodies (mainly local authorities).

In the CCG information there are substantial amounts being paid to care homes and home care providers for 'continuing health care' (CHC) and 'funded nursing care' (FNC).

These figures are included in the calculations for total healthcare expenditure.

Why can't you get a GP appointment?

How long do people have to wait for a GP appointment?

It is common for patients to have to wait over a week and in some cases much longer for a routine appointment with a GP. Most surgeries run a system for same day appointments, but these slots go quickly, sometimes only minutes after surgeries open.

Waits have increased over the past few years. In the report - NHS Pressure - Winter Crisis 2018/19 - the BMA found that the number of patients waiting over two weeks for an appointment with their GP was up by 13% compared to the same months in 2018.

Appointments with a wait of over 28 days were up 15% on the previous year rising to 2,230,000.

Social media has shown instances of patients queuing outside surgeries before they open in order to get appointments: one person reported that patients in Wellingborough were queuing 75 minutes before surgery opening time.

Why is this happening?

The simple answer is there are not enough GPs. Despite a government promise in 2015 of 5,000 more GPs, data from NHS Digital released in April 2019 shows that there has been a 4% fall in full-time equivalent (FTE) GP numbers between September 2015 and September 2018; there are now 1,180 fewer GPs than three years ago.

A longer term look at GP numbers by The Nuffield Trust concluded that there had been a "recent sustained fall" in GP numbers relative to the size of the UK population. This is something that has not happened since the 1960s.

The fall in GP numbers comes at a time of population growth, according to The Health Foundation, with the number of people registering with GPs up 3% over the past three years. As a result the number of patients per GP has risen by 8%.

Does the situation vary across the country?

Some areas of England are having more trouble than others recruiting and retaining GPs, with areas considered to be deprived or very isolated from large cities having the most difficulties.

Between 2008 and 2017, the number of GPs working in the most deprived 20% of areas fell by 511, in contrast to the wealthiest 20% where 134 additional GPs were recruited. As a result, these areas often have the worst waiting times for appointments.

Nuffield Trust figures for 2018 found that England fared the worst of the four nations, with 58 GPs per 100,000 population, and within England regional differences were marked, with the East of England and North West London having the lowest levels of 54 per 100,000.

The Nuffield Trust also shows that there are significantly fewer GPs per head of population in the more deprived areas of England than in the richer areas. In the most deprived fifth of CCG areas there are 47 GPs per 100,000 people, compared to 53 GPs per 100,000 population in the least deprived fifth of CCG areas.

One notable area is Swale in Kent, a deprived area, where in 2018 one surgery in Shepway had just one GP per 4,196 patients registered and another had one GP per 3,847 registered patients.

As a result of these low GP numbers, patients in deprived areas find it harder to get a GP appointment and have a poorer experience of primary care.

Even in the much more affluent area of Oxfordshire, GP shortages are hitting patients. The Oxford Mail reported that in March 2019 more than 13,900 patients had to wait longer that four weeks for a GP appointment in the area. The CCG area is reported to be 21 GPs short.

Cartoonstock

Between 2008 and 2017, the number of GPs working in the most deprived areas fell by 511, in the wealthiest areas 134 additional GPs were recruited

Why is the number of GPs falling?

The fall in the number of GPs in England is due to a combination of factors, including: a lack of junior doctors entering training to become GPs; a rise in the number of trained GPs leaving the NHS, either to work abroad or taking early retirement; and a rise in the number of GPs choosing to work part-time.

Surveys of GPs have found that the primary reason given by GPs for leaving the NHS, including retiring early, is increasing workload, including administration.

In 2014, a study on GP morale and future plans found that one in five GPs intended to retire within the next five years.

A follow-up study in 2018 published in BMJOpen found that morale had reduced further over the preceding years and almost half had brought forward their plans to leave general practice.

The most common reasons given for leaving sooner than previously planned were work intensity and workload. The heavy workload of GPs is impacting on their health and as a result more and more are planning to either quit the NHS or go part-time.

How many GPs do we need?

The report by the King's Fund, The Health Foundation and the Nuffield Trust, Closing the Gap, noted that the NHS will be 7,000 GPs down in five years time if the current trend continues, despite an increase in training places for GPs.

With the regional discrepancies, however, this will mean that some areas, will feel this shortfall much sooner than others; GP Online confirmed that GP numbers are falling fastest in the most deprived areas.

What is being done to increase the number of GPs?

In 2015, the government promised 5,000 more GPs by 2020. The main target for NHS England has been an increase in training and recruitment of GPs from abroad.

In 2016, the 'golden hello' was introduced for trainee GPs who applied for places in certain areas, that found it difficult to attract trainees.

The trainees were given a £20,000 payment for agreeing to stay for three years of training in the area. The 2018-19 scheme filled its 265 places.

There has also been an expansion of training places overall, with a record number entering training in 2018/19, according to NHS England.

NHS England is also recruiting GPs from abroad. The international recruitment scheme was launched in April 2016 with a target of 500 GPs by 2020.

It was relaunched in August 2017 with an increased target of 2,000-3,000 GPs by 2020.

Are the incentives working?

The simple answer is no, the data published in April 2019 clearly shows that despite incentives from NHS England, there is no way the NHS is going to have 5,000 more GPs by 2020.

In January 2019 the Health and Social Care Secretary admitted that the 2020 date was no longer a target, but failed to set a new target date.

In February 2019, CCGs involved in international recruitment process reported that they have had to cut their targets and NHS England admitted that only just over 70 GPs have been recruited so far and only 50 of these have entered the country. Despite this the scheme has been extended to 2023/24.

In May 2019, recruiters involved in the process, told Pulse that Brexit is putting off potential GPs, even those GPs seeking to return from Australia.

What does the future look like?

NHS England are hoping to ease the pressure by creating new collaborations to share GP work, with pharmacists and Physiotherapists and by grouping GPs into bigger practices.

This strategy appears to acknowledge that the GP recruitment strategy is failing and puts new emphasis on attempting to manage demand through different ways of working.

Local GP practices are being asked to merge together in to Primary Care Networks serving 30-50000 patients each.

They will keep their existing GMS contracts and their current relationship as part of the wider NHS network, but by agreeing to the change they will access new funding to take on seven new areas of work including; structured medication reviews, enhanced health in care homes, anticipatory care (with community services), and work on early cancer diagnosis.

The Kings Fund cites the fact that Wales, Scotland and Northern Ireland have already implemented similar models:

"In Scotland, a key feature of the new GP contract has been the obligation to become part of a geographical quality cluster."

The think tank reports that these have generally worked well, except when covering a mix of urban and rural practices that face different issues.

However GP practice leaders are worried that the new structures mask a likely increase in workload, over 50% supported this view in a survey report by GP online. This is a concern which could well stem from the NHS long term plan, which has a headline goal to transfer more treatment out of hospital and into the community.

The Government has chosen to target training and international recruitment, despite the overwhelming evidence that GP retention is a major problem

What should the Government be doing?

Health commentators are agreed on the urgent need for a well funding national workforce strategy, a document that, several months on from the NHS plan, has yet to be published.

The Government has chosen to target training and international recruitment, despite the overwhelming evidence that GP retention is a major problem.

At the moment, the numbers of doctors training to be GPs may have increased, but without changes to the working conditions, it is unlikely that enough will stay in the profession.

At present, primary care is in a vicious circle - as GPs leave and are not replaced working conditions for the remaining GPs get worse causing more to leave.

Manageable workloads, support for staff wellbeing and strategies to prevent dangerous stress are all needed to keep GPs working according to many GP organisations

In May 2019, the Royal College of GPs published Fit for the Future – in 3,000 GPs talk about what will make a difference.

This included an end to the 10 minute appointment, with patients able to have 15 minute or longer appointments, improvements in continuity of care and an end to isolated working.

For the college's vision of the future to work, the report states that changes will have to be made, including: "general practice receives at least 11% of the NHS budget in all four nations of the UK; the full-time equivalent GP workforce expands by thousands, as does the wider practice team workforce; and that GP specialty training is extended to at least four years to expose trainees to the full breadth of skills and conditions they are likely to need and see in general practice."

THE lowdown

Health news, analysis and campaigns.
NUMBER 4, June 8 2019

Informing, alerting and empowering NHS staff and campaigners

PAH strike threat forces trust to keep services in-house

Domestics at Princess Alexandra Hospital in Harlow called off planned strikes after their employer dropped plans to outsource their jobs and pledged to keep the service in house.

The Trust had been market testing its cleaning and catering services with the aim of putting them out to tender.

Domestics voted by 99% to strike against the changes and were preparing to take six days of action, backed by UNISON.

Trump is not the problem: ministers are

Few people could have had any illusions that the British public would react positively to American corporations moving in on our NHS.

So what have we learned from the huge public reaction to the US Ambassador and then Donald Trump himself insisting that the NHS – and of course its budget of £120 billion a year – had to be on the table in any trade negotiations?

Tory leadership hopefuls predictably hastened to distance themselves from any toxic association with Trump's demands.

The public view was shown by over 300,000 people rushing to sign the petition launched by Dr Sonia Adesara, and promoted by Keep Our NHS Public, to "send a message to Donald Trump to keep his hands off our NHS, and ask the UK government to explicitly guarantee that it will never form part of a trade deal with America".

Trump himself appeared to retreat slightly from his original statement in an interview the next day with Piers Morgan; but it would be a mistake to take either his opening gambit or his subsequent statement at face value – or to trust any British government rejection.

Trump will have known that the NHS is already open to private companies to bid for contracts.

But up to now the main US health corporations have shown little interest in bidding for under-funded contracts to deliver patient care.

Nor are the major US insurers significantly engaged in the UK, even as gaps appear in the NHS. US hospital giants HCA and Tenet also have only a minimal foothold, but no large scale commitment to expand in Britain's small private hospital sector.

The Canadian government rejected any US involvement in their health care system, even while signing the NAFTA free trade deal

Instead US companies like UnitedHealth subsidiary Optum have focused on selling technology, IT expertise and "back office" systems. And of course the main potential money-spinner is pharmaceuticals, especially if Trump could strip away existing regulations and NICE guidelines, and force British prices up to the inflated levels they are able to charge in the US market.

The government have shown they are happy to accept all of these, except perhaps the drug price hikes, which would push up public spending.

So their denials are as phony as Trump's retreat. Remember it was British governments that created a competitive market in the NHS. They have opened it up to EU competition laws more than any other EU country.

It's been possible for governments, like the Canadian government, to reject any US involvement in their health care system, even while signing free trade deals.

France and Germany have also protected their much bigger health care against competition laws and have little if any US penetration.

It's not Trump or the US who have privatised sections of our NHS but British governments, and predominantly British companies such as Virgin.

To make sure we keep our NHS public, we need a government committed to do just that – not one led by any of the right wing hopefuls lining up to replace Mrs May.

IN THIS ISSUE

Brum trust gambles on Babylon's chatbot

John Lister

The massive £695m PFI-funded Queen Elizabeth Hospital in Birmingham is struggling with a rising tide of emergency attendances (up almost 8% since last year) and emergency admissions (also up by 8%); its 1200 beds are not enough to cope with local needs, the once prestige hospital is slipping down the performance league table – and its chief executive Dr David Rosser is getting desperate.

The scale of the emergency caseload is so great, with its pressure on acute hospital beds, that there is insufficient capacity to meet targets for treating elective patients, leaving numbers treated from Birmingham & Solihull CCG 11% below last year.

According to a paper presented by Dr Rosser to the Board on May 22 (but not yet available on the Trust's website):

"Patients who entered hospital on a non-elective pathway now account for over 90% of bed days across the trust so we have less than 10% of bed days to run our admitted, elective programmes."

"[…] to deliver our strategic aims and support future sustainability we must find ways to reduce unnecessary footfall at hospital, both outpatients and ambulatory care through ED, repurpose parts of the hospital estate to focus even more on acute and tertiary care, and better manage frailty and chronic disease in the community to reduce avoidable hospitalisation."

So desperate is the situation that the trust is looking to the unproven technological solutions offered by Babylon, the company behind GP at Hand, the online GP service controversially endorsed by health secretary Matt Hancock.

Babylon is led by Ali Parsa, the mercurial salesman best known for creating Circle Health, which runs small, unsuccessful private hospitals and which failed so spectacularly on a 10-year contract to manage Hinchingbrooke Hospital.

"Patients on a non-elective pathway now account for over 90% of bed days across the trust"

Parsa left Circle before it hit the buffers at Hinchingbrooke, and is now busily talking up what he claims is an "artificial intelligence" chatbot, and using this and a huge expansion of the workforce as the basis to attract up to $400m of investment income. The company lost money in 2016 and 2017, and appears to be spending contract income as soon as it comes in.

The UHB board has now agreed to explore using Babylon's services, including video appointments and digital triage, in the hope it might help divert pressure from its severely strained hospitals.

"We would like to explore whether an AI symptom checking tool, such as Babylon's AI symptom checker, currently designed for and aimed at primary care, could be developed for use in relation to urgent and emergency care. … Used in this way, it would provide the AI symptom checker through a chatbot, backed up by UHB's clinicians."

Just two days after the UHB board rubber stamped Rosser's plan, Hammersmith & Fulham published a worrying review by Ipsos Mori of Babylon's 'GP at Hand' system.

It pointed out that while GP at Hand appears to satisfy the mostly youthful and affluent punters who have signed up (94% of GP at Hand patients are aged 45 or under), the app offers little or nothing to many of the older age groups, who are likely have most need of health care.

But these are also the type of patient most likely to be among the rising numbers of A&E attenders Dr Rosser is trying to deter from coming to QEH. So it's hard to see how Babylon can help, even if it works as well as the company claims.

The report also fails to answer key question of the cost-effectiveness or sustainability of the GP at Hand model. This is both because of "the absence of data on patient outcomes" (effectiveness) – but also because Babylon itself invoked "commercial sensitivity reasons" for refusing to divulge data on the costs of involved.

UHB is potentially thinking of signing up with a private company that will not share key information.

Dr Rosser is also burning any possible bridges by embarking on a policy that he knows will enrage Birmingham GPs. They were already angry at plans by Babylon to extend GP at Hand to Birmingham, which is likely to siphon off many of their younger, fitter patients who are cheaper to look after, and leaving them the older ones with greater health needs who will drive up costs.

The GPs have said they regard the potential deal with Babylon as the trust seeking ways to cut them out of deciding which patients should be referred to outpatient appointments with specialists.

They reject what the Local Medical Committee secretary describes as "an ill-thought through and destructive takeover".

So while most proposals for longer term integration of services recognise that primary care must be a key player, Dr Rosser has decided to put two fingers up to them, and trust in Ali Parsa's questionable company with its unproven app and its dodgy diagnoses.

It could end in tears.

Work has begun on building a new £100m 138-bed private hospital on the QEH site as part of a partnership agreement between the Trust and US hospital giant HCA. HCA is financing the construction and will use 66 beds for private patients, leasing the remainder to the Trust.

Babylon covers its tracks

Babylon, the controversial company behind GP at Hand, which is destabilising primary care in London and set to extend to Birmingham, appears to be keen to cover up the traces of a discredited test of its online triage service last summer.

The company has been hard at work deleting all of the details of what was at first a much-vaunted comparative test, in which the chatbot's performance was presented as superior to that of real trainee GPs.

At first the company was quick to boast that this test proved that its software was superior to real doctors. But Babylon's claims immediately came under increasing critical fire from doctors and AI experts, who questioned the validity of the test, and revealed the various ways in which it was skewed to make the chatbot's performance appear better.

GPs consultants and IT experts also pointed out that, contrary to the incessant rhetoric from Parsa and others, Babylon's chatbot software is NOT based on AI at all, or even very innovative.

It is built on 'Bayesian Reasoning' – a system used to build systems in the 1970s. In other words meaning the chatbot has not been trained on a dataset, and does not "learn": it only knows what it has been told.

Contrary to the incessant rhetoric from Parsa and others, Babylon's chatbot software is NOT based on AI at all.

The many errors in its diagnoses which have been reported have only been corrected by human intervention, and by effectively reprogramming the machine.

'AI News' has since discovered that the video of the test event has now been deleted from Babylon You Tube account, and all links to the news coverage of the event have been removed from the company's website.

The link to Babylon's own conference paper describing the chatbot has also been deleted; in other words all of the company's boldest claims for the performance of the software now appear to have been quietly dropped.

When questioned about the deletion by AI News, Babylon's response was simply to add the excuse that "As a fast-paced and dynamic health-tech company, Babylon is constantly refreshing the website with new information about our products and services. As such, older content is often removed to make way for the new."

So yes, they have deleted the data.

critics have all argued that in real life the chatbot's results would be nowhere near as good as it appeared in the test, and that in some cases dangerously wrong advice could be given. Now it seems Babylon has given up trying to refute them.

The new Emergency department looks good – but the bed shortage is unresolved

New A&E building just makes matters worse in Croydon

Croydon's overstretched University Hospital has been bumping along at the bottom of the performance tables for some time.

In January 2019 it became the first hospital to dip below 50% of the most serious Type 1 A&E patients to be seen and treated or admitted within 4 hours. Indeed Croydon Health Services Trust's 29 percentage point drop over 2 years – to just 49.1% type 1 performance in January 2019 made it the worst in the NHS, 27 points behind the 76.1% average.

But now it appears that a contributing factor to this has been the opening of a brand new £21m A&E department, almost 2 years later than scheduled, last December: there had been problems with contractors, plumbing and asbestos.

But the new department, which the trust claimed had been planned with the involvement of medical and nursing staff, has proved to be a liability rather than an asset.

According to analysis by the South London Press:

"In the three months before the changeover, Croydon University Hospital's A&E was performing very similarly to the national average for Type 1 patients. … There was a small decrease in December, with an extra 5% of patients having to wait longer than four hours. In January, however, more than half of Type 1 patients in A&E waited longer than four hours to be seen."

In February the performance increased, but only to 63% of Type 1 patients waiting less than four hours, and in March it slumped again to 60%.

Croydon's trust's acute bed capacity decined from 523 beds in 2010/11 to 477 (plus a flashy new A&E) in 2018/19

By comparison Croydon's overall figure for Type 1 and Type 3 minor cases was much higher, with 85% in February and 84% in March.

The trust's response has been to blame the problems on a significant increase in demand for emergency admissions and the lack of available beds.

This is clearly a key issue. No matter how you enlarge the A&E as the entrance hall for patients, if the bed numbers are inadequate, performance will be limited.

This problem is a miniature version of the NHS as a whole, where huge amounts of management time and effort in recent years have been devoted to channelling away as many as possible of the less serious type 3 patients from A&E, even though these patients are not the ones facing the biggest delays and do not require beds.

Meanwhile they have been paying little attention to the growing delays for those in most serious need of attention.

Since 2010 the UK population has increased by over 4 million and the numbers of older patients more likely to need health care has also risen

However front line general and acute bed numbers in England have been cut by almost 6,000, with Croydon's trust's capacity declining almost 9% from 523 beds in 2010/11 to 477 (plus a flashy new A&E) in 2018/19.

Swindon primary care left stranded by contract failure

By Samantha Wathen (Media/Press Officer and writer for Keep Our NHS Public)

The future of 54,000 patients is uncertain after private company Integral Medical Holdings (IMH) has withdrawn from five Swindon GP practices it was contracted to run.

The mismanagement of general practice in Swindon and subsequent abrupt withdrawal of IMH means that five GP surgeries, over 100 members of staff and 54,000 patients now face an uncertain future.

Three partners are due to resign over the shambolic takeover of surgeries that took two practices from a CQC rating of good to requiring improvement or inadequate earlier this year.

Following an unannounced inspection at one of the surgeries affected Prof Steve Field, chief inspector of general practice at the CQC, said:

"We found there has been insufficient management infrastructure and insufficient leadership capacity and capability. There are significant concerns regarding the lack of effective governance and oversight to ensure quality and safety are not compromised."

Primary Care Networks will be introduced in a matter of weeks and NHS England have no plans to ease this deadline for the practices affected.

The way private company IMH has run the five GP surgeries in the town has meant significant problems for patients accessing appointments since autumn.

The arrangement was presented as a way to relieve the burden on clinicians to focus on patient care and ease the crippling financial pressures caused by sustained underfunding of general practice.

However, those employing this company should have done their homework. IMH have a troubled history.

In March 2017 the company hit the headlines when one of their practices in Kent was found to have five receptionists but no doctors after full time members of staff resigned, leaving the practice relying on locums.

There are also other examples of practices across the country going from a good CQC rating to inadequate as a result of an IMH takeover.

Dangerous practices

In Swindon the company quickly cut their costs by reducing essential administrative staff at practices by 50%. Without informing patient participation groups 75 staff were squeezed into the equivalent of 36 full-time roles, placing extra stress on those that remained.

A new call handling hub was introduced, immediately taking the time spent waiting on the phone to around an hour on average.

In addition, patients complained of dangerously muddled prescriptions, and long delays to access appointments.

According to a local member of staff working at the Great Western hospital one patient even required emergency surgery due to not being able to access their GP.

The situation deteriorated to such an extent that it drew the attention of the shadow health secretary Jonathon Ashworth who in November waded into the debate, raising the issue in parliament.

Following an unannounced inspection last month, the CQC issued IMH (now trading in Swindon as the Better Health Partnership) with an enforcement order to improve.

This prompted the resignation of Dr Peter Mack, the lead partner, from his director role at the CCG. IMH CEO Martin Diaper followed suit a week later.

After a protest outside the CCG by Keep Our NHS Public campaigners who have been exerting pressure from the start (photo above), the CCG finally informed IMH the contract had been breached, issuing a remedial notice requiring improvements.

The next day IMH announced their intention to withdraw from the five surgeries they were managing.

The abrupt withdrawal of IMH means five GP surgeries, over 100 members of staff and 54,000 patients now face an uncertain future

What next?

With hundreds of GP surgeries closing around the country the CCG and campaigners have a difficult time ahead but a solution must be reached, ideally with an NHS provider taking over the reins. Kate Linnegar, Labour prospective parliamentary candidate who has been campaigning on this with Keep Our NHS Public since the problems started, says:

"It's vitally important that the CCG oversee a smooth transition for patients who have suffered enough. Some NHS Foundation Trusts have taken GP surgeries inhouse, cutting out the need for a private profit-making company to be involved. I would urge Swindon CCG to consider this alternative."

IMH have effectively driven a wrecking ball through general practice in Swindon and should be held accountable. Private firms can and will walk away when the going gets tough, leaving the NHS to pick up the pieces.

The NHS cannot and will not do this, and that is just one reason why privatisation poses such a threat to our health system.

NHS England retreats – to insist lead providers must be NHS bodies

NHS England has made an ungainly climbdown from its initial plan to allow private sector providers to play a role in allocating specialist mental health commissioning budgets with a total of more than £2 billion.

In a move which Health Service Journal report links to criticism by campaigners of this new level of involvement of private companies, NHS England has written again to all providers of mental health, learning disability and autism services to make clear that private firms are excluded from leading the new models of care.

NHS England's letter includes public and private sector in an invitation to "all providers of specialised mental health, learning disability and autism services to make submissions, through a regional process, to form NHS led provider collaboratives from April 2020."

But it makes clear that the leading role in each collaborative has to be "**an NHS organisation** with experience of delivering specialised mental health and/or learning disability and autism services."

Victory for Liverpool ISS strikers

Hospital staff from all the main unions at Royal Liverpool and Broadgreen Hospitals suspended planned strike action on May 30 after a major contractor agreed to give them a pay rise.

The low-paid workers – who provide cleaning, porter and catering services – were due to walk out on Thursday May 30 2019.

But outsourcing giant ISS Mediclean agreed to match the same percentage pay rise other members of staff across the NHS have received – and back date it to the start of the 2018/19 financial year. Michael Evans, GMB Organiser, said:

"GMB members stood firm and - with the help of members of sister unions and Mayor Joe Anderson – they got the result they deserved."

Julie Simmonds

PET scanner issue not the only problem prominent on placards on a protest called by Oxfordshire Health UNISON on June 1

No end to Oxford's PET scan-dal

The fight against the privatisation of specialist PET-CT scanning services in Oxfordshire, Swindon and Milton Keynes shows no sign of abating, despite determined efforts to face down the protests.

Despite all-party pressure from MPs in Oxfordshire and from the Tory-led County Council, whose Health Oversight & Scrutiny Committee referred the case to health secretary Matt Hancock, he is refusing to review the decision to give the contract to a private company, InHealth. The Department of Health has also refused to respond.

Hancock has said that he will not step in because a "partnership" is being formed between the company, which does not have the specialist staff required to deliver the service, and Oxford University Hospitals Foundation Trust, which currently runs the service at the Churchill Hospital.

"Partnership" is a strange word to use for an arrangement in which the existing provider is pushed aside by an unwanted private company which is given control of the contract, but the NHS trust is then expected to work for the company to ensure the service is delivered.

Oxford East MP Anneliese Dodds has lodged a formal complaint at the scoring system used in the procurement, which resulted in the contract going to a company without facilities or staff to carry it out.

Meanwhile the local National Union of Journalists branch has called a public meeting to challenge the threats by NHS England to use legal action alleging defamation if the Trust or its staff speak out to expose the dangers to patient care posed by the contract.

The meeting on June 20 will argue "We all have a right and a duty to voice and report serious concerns". Speakers include outspoken cancer specialist Prof Adrian Harris, lawyer Tamsin Allen from Bindmans solicitors who has acted for whistleblowers and NUJ Deputy General Secretary Seamus Dooley.

What's the government's plan to help our GP services – and will it work?

PAUL EVANS

The pressure on GPs is evident across the NHS and a recent study shows that their numbers have actually fallen for the first time since 1960s. NHS England are calling on GPs to form new Primary Care Networks which they say will solve many of the current problems.

Being a family GP is not as desirable as it used to be. Patient demand is rising. Millions more are living with chronic conditions. Our needs as patients are more complex and often dealing with them won't fit into the average 10 minutes consultation time - the shortest in Europe.

GPs don't shy away from the challenge, but often when their patients talk about their symptoms they are also describing society's ills; family breakdown, money worries, social exclusion, which need a wide set of policy answers, not simply a prescription.

We now know that austerity has blunted our response, limited the treatment options and caused thousands of unnecessary deaths. Delays in mental health are dangerously high. Drug and alcohol services have been cut back, social care is by popular view on its knees and spending on preventing illness has gone down when it needs to be a high priority.

Its easy to see how a GP could be overwhelmed and demoralised and it's the reason why many are leaving the profession.

Plans to raise GPs numbers have been tried but have so far failed. Despite a government promise in 2015 to bring in 5,000 more GPs, data from NHS Digital shows that there are now 1,180 fewer than three years ago.

Despite a government promise in 2015 to bring in 5,000 more GPs, data from NHS Digital shows that there are now 1,180 fewer than three years ago.

PRIMARY CARE NETWORKS

In an attempt to lift the pressures on GPs, NHS England are reorganising primary care to help spread the workload. NHS England claim that the process is well underway.

"practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas."

GP leaders are being asked to merge their practices together to serve larger groups of patients. These new Primary Care Networks will care for 30,000-50,000 patients each.

The vision is that GPs will work more closely with a wider group of health professionals including pharmacists, district nurses, community geriatricians, physiotherapists and podiatrists in 'expanded neighbourhood teams'. New money is already being targeted at these areas.

NHS England believe that introducing new ways of working will help to manage patient demand but also create better organised care that is more 'personalised' and more often sited in the community.

Commentators acknowledge the potential, but many point to the fact that there is a real risk that a lack of staff will derail the plans.

A BOOST IN STAFFING?

The NHS needs 7000 more GPs, but most of the health professions delivering care alongside GPs are also heavily overworked and understaffed. Nursing unions have pointed out that the capacity of community services has fallen sharply in recent years.

There has been a 50% fall in the number of district nurses between 2010-17.

There are a fifth less health visitors since 2015 and a 12% drop in mental health nurses over the last decade.

While the number of GPs has fallen the number of patients has risen by 16% more patients over the last seven years.

Gaps in other key area like social care have cranked up the pressure on primary care. Cuts in social care funding to local authorities have led to a 25% drop in the number of people that are accessing these services.

GPs confront the fallout from these vanishing services on a daily basis, dealing with patients whose health problems have not been caught early and doing what they can to help patch together the right care.

ENOUGH FUNDING?

NHS England acknowledge the staffing crisis and have set a goal to boost the primary care workforce by 20,000 in the next five years. Seventy per cent of the funding for these posts will come from government - £891 million of new annual investment by 2023/24, but PCNs must find the rest.

However, introducing PCNs will not bridge the existing capacity gap. NHS bosses agree that their number one problem is a lack of staff – as a whole the health service has a shortfall of 100,000 staff and counting. GPs and community services are bowing under the weight of current demand and yet NHS England intends for PCNs to take on far more work.

This reality should urge NHS leaders to argue more vigorously for the resources to raise NHS capacity, when they take part in the government's comprehensive spending review across the summer.

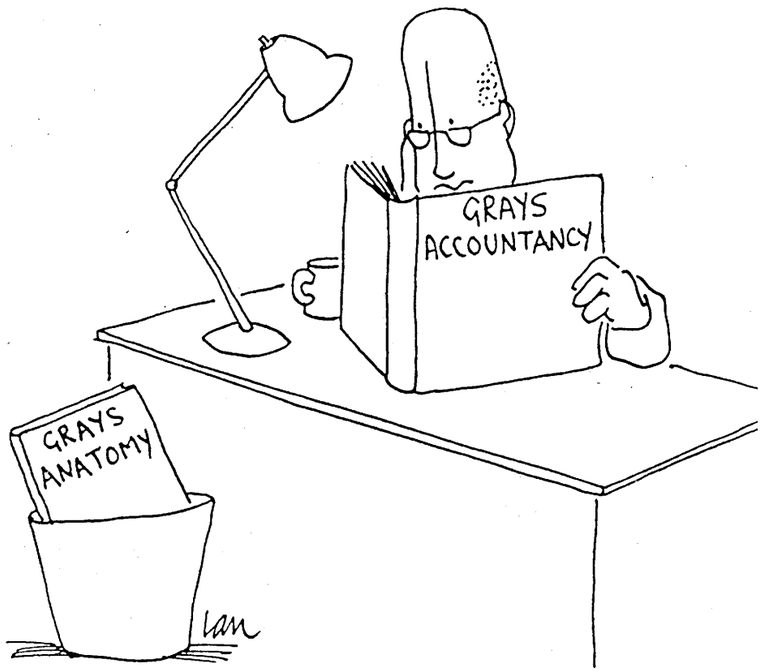
At local level GPs leaders are being incentivised to join PCNs allowing them to unlock access to extra funding. Most are complying, some are enthused, but most are desperate for an increase in real terms resources after a decade long financial squeeze.

PCNs will received an annual uplift of £1.50 per patient from CCGs and funding for extended opening hours and access. The government committed £4.5bn of the £20.5bn new funding it announced last summer to directly boost primary care.

The Health Foundation has criticised the size of the funding settlement and has also suggested it is unfair, saying that the extra money will not be shared out according to an equitable weighting system.

"networks servicing populations with the greatest needs will continue to do so with disproportionately fewer resources."

The Health Foundation has criticised the size of the funding settlement and has also suggested it is unfair, the extra money will not be shared out according to an equitable weighting system



REALISTIC EXPANSION?

From NHS England's perspective the need to get PCNs up and running is pressing. Many of the headline promises from their long term plan are ambitious, but have also ratcheted-up expectations.

At its launch NHS bosses proclaimed that their new 10-year strategy "could save up to 500,000 lives by focusing on prevention and early detection."

They want much of this to be delivered through primary care networks.

As they grow PCNs are expected to take on seven new areas of work including; structured medication reviews, enhanced health in care homes, anticipatory care (with community services), and work on early cancer diagnosis.

There is talk of dashboards and metrics to measure PCN performance. Part of the extra investment will depend upon their impact upon controlling A&E attendances, emergency admissions, hospital discharge and prescribing.

A further stand out promise from the long-term plan says that one in three patients are to receive care from newly enhanced community-based services, rather than going to their local hospital for an outpatient appointment.

This totals a startling 30 million clinic visits a year, patients which NHS England now intends to divert towards services in the community.

The detail on how PCNs will vault from their fledgling status into something capable of satisfying these sizable new demands is unclear, a fact which is leading commentators to suggest that NHS England has unrealistic ambitions.

The Kings Fund supports the move towards PCNs but think that they have a lot to contend with.

"there is so much that is still unclear and that could go wrong – a lack of development and workforce support, overly onerous performance management and managing relationships in primary care to name a few."

GP practice leaders are worried too that the new structures mask a likely increase in workload, over 50% supported this view in a survey reported on by GP online.

The detail on how PCNs will vault from their fledgling status into something capable of satisfying these sizable new demands is unclear …

A VEHICLE FOR PRIVATISATION?

A further concern is that PCNs will open the door for more commercial involvement in primary care. Virgin Care, Care UK and a host of smaller commercial outfits have been involved in running GP health centres and urgent care centres in numerous sites around the country.

A good number of these contracts have failed, after poor performance or profits have stalled.

Providers have then walked away. What room is there for private companies to exploit PCNs as a further business opportunity?

Louise Irvine a GP and campaigner against privatisation has analysed PCNs on behalf of Keep Our NHS Public. She believes that because the current GP contract (GMS) will remain in place the relationship between GPs and their local health commissioners will not change.

"Practices will not have to give up their patient lists to the PCNs, and patients will still be registered with their individual practice and receive core medical services from their existing practice team."

According to her analysis that primary care networks are not directly linked to recent drives to encourage private sector involvement.

"PCNs are very different to the proposed Integrated Care Provider (ICP) model, promoted by NHS England (NHSE), and which KONP vigorously opposes, whereby GPs would give up their practice contract and patient list and merge into a massive organisation covering upto hundreds of thousands of people."

However, one commercial provider - Babylon, has spotted an opportunity and has applied for its GP at Hand service to become a primary care network – a move that risks "destabilising" GP services in London, according to the London-wide local medical council.

Babylon is a private company that has sparked controversy by running a digital GP service for NHS patients, attracting 40,000 mostly younger patients from across the country, who in signing up to the London based service de-register from their existing local GPs who then lose funding.

The GP firm have perhaps been encouraged by the new government funding, although it is difficult to see how their digital service could work along-side the other professions in the health network.

A POPULAR SOLUTION?

So far GP organisations have cautiously supported PCNs seeing the chance to reorganise care with some much-needed new funding.

Everything rests on solving the workforce crisis and how these new organisation work in practice.

NHS England took the first step this week and there must be a dramatic turnaround in achieving these workforce targets.

However, the NHS England's ambitions for PCNs seem dauntingly large. Under their plans PCNs have a big part to play in shifting healthcare from hospitals into the community, for improving detection and outcomes and for adopting a raft of ground-breaking new technology.

It could well be too much for an already creaking service.

I hope those already knackered GPs weren't expecting a rest.

Billions are spent by the NHS on drugs every year – but how does it work?

How much does the NHS spend on drugs per year?

According to the most recent data from NHS Digital, in 2017/18 the overall drugs cost at list price in the NHS, before any discounts, was £18.2 billion.

This is an increase of 4.6% from £17.4 billion in 2016/17 and an increase of 39.6% from in 2010/11.

Hospital drug use accounted for just over half (50.4%) of the total at £9.2 billion (2017/18). In fact total hospital costs are up by 10.8%, compared to a 1% decrease in the primary care sector over the most recent year.

How are prices set in the UK?

Pharmaceutical products in the UK are priced by the manufacturer and are not subject to direct price controls.

Companies set the price of drugs based on a number of factors, including the number of patients it will benefit, how many similar drugs are on the market and the price of competing products.

Although, there are no direct price controls in the UK, the price of pharmaceutical products are controlled via indirect processes, discussed below.

The prices that the NHS will pay for a pharmaceutical product are published monthly in the drug tariff. This price is known as the list price and is normally what pharmacists will be reimbursed when they dispense the product.

How do prices in the UK compare to other countries?

It is not easy to compare drug prices across markets due to the complicated nature of rebates and discounts that operate.

It is however clear that drug prices in the UK are much lower than in several other developed markets and substantially lower than in the USA.

In 2017, the Commonwealth Fund investigated why health spending was so much higher in the USA, than in nine other developed markets, despite similar drug usage. Its conclusion was that

"While drug utilization appears to be similar in the US and the nine other countries considered, the prices at which drugs are sold in the US are substantially higher."

The report noted that the reasons for markets outside the USA, having much lower prices included certain price control strategies, like centralised price negotiations.

One example of high prices in the USA compared to the UK is the cost of insulin. A BBC story reported in March that retail prices in the US are around £220 per vial, for all insulins from the three major brands that control the market.

By comparison in the NHS there is no insulin listed that costs more than about £20 for one vial and many are much cheaper.

How does the NHS keep prices low?

For a pharmaceutical company, the NHS in the UK is the country's market; the private healthcare market is tiny in comparison to the NHS. If the NHS won't buy your products then you have no real market share.

Such centralised buying power gives the NHS the upper hand to a great extent in pricing negotiations and discounts based on volume sales.

On top of this buying power, prices are controlled through a number of indirect methods, including: a voluntary agreement between the industry and the government that covers the profit that companies can make on drugs; and for new drugs, an assessment by the National Institute for Clinical Excellence (NICE) of cost-effectiveness prior to a recommendation for use.

"While drug utilization appears to be similar in the US and the nine other countries considered, the prices at which drugs are sold in the US are substantially higher."

What agreements are there between the pharmaceutical industry and the NHS?

In the absence of direct price control mechanisms, successive UK governments have for many years relied on agreements with the pharmaceutical industry and market competition to keep drug costs from spiralling out of control for the NHS.

There is a voluntary agreement, renegotiated every five years, between the Association of British Pharmaceutical Industries (ABPI) and the Department of Health which covers the vast majority of branded products, i.e., those still covered by patents.

Under this scheme, originally known as the Pharmaceutical Pricing Regulations Scheme (PPRS), the industry members agree to a variety of measures to control prices and spending by the NHS.

The primary control is the payment mechanism, whereby members of the scheme make payments 'back' to the NHS if growth in NHS spend on branded medicines supplied by the scheme's members exceeds an agreed percentage.

In January 2019, the PPRS was revised and renamed the Voluntary Scheme for Branded Medicines. The cap for increase in costs to the NHS was set at 2%.

If in any of the next five years, the rise in drug spending by the NHS is above 2%, then the industry that has signed up to the scheme is required to pay back the NHS the overspend.

Around 80% of branded products are covered by the voluntary scheme. Branded products not covered by the scheme are included automatically in a statutory scheme, which also has a payback mechanism.

What products aren't covered by the voluntary or statutory scheme?

Generic medicines, those that are not protected by patents, are not covered by any price control scheme. UK governments have relied on market competition to control the prices of these products.

This has worked to a large extent, generic versions of best-selling branded products are sometimes 90% cheaper than the original branded products.

There has been a problem, however, with relying on market competition. Although a product may be old and produced as a generic, it will not necessarily have many or in some cases any competitors on the market. Some manufacturers took advantage of this situation and hiked the price of a generic product year-on-year knowing that there could be no comeback.

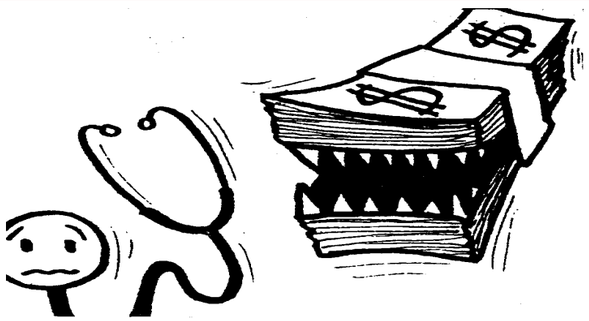
There have been cases where prices for some generics rose dramatically leading to a sudden increase in NHS costs.

An article in Pharmaphorum reported that dramatic price increases included the anti-epilepsy drug phenytoin sodium, the price of which was reportedly in-

continued overleaf, page 10

NHS our best defence against big pharma profit grab

Two instances of high drug prices are denying thousands of NHS patients the care they need, despite the power of the NHS in negotiations and indirect pricing controls, which for many years have kept drug prices in the UK low in comparison to the USA and other markets.



The Guardian has reported on the frustrated moves by the NHS to make the cystic fibrosis drug, Orkambi available to patients.

As the negotiations between the manufacturer Vertex and the Department for Health have reached a stalemate, parents of children who will benefit from the drug are planning on forming a buyers' club to obtain a generic version from Argentina.

Vertex, the manufacturers of Orkambi, has priced the drug in the UK at £104,000 per patient per year.

An identical version known as Lucaftor can be bought in Argentina for £20,000 per patient per year. The patent does not apply in Argentina, but the NHS can not obtain this product itself due to patent protection in the UK.

Orkambi was licensed for sale in the UK four years ago, but the National Institute for Clinical Excellence (NICE) refused to okay the product's use at such a high price in the light of the data available at the time.

There are 10,400 patients with cystic fibrosis in the UK, 40% of whom could benefit from Orkambi

In the summer of 2018, Vertex rejected an NHS offer of £500m over five years and potentially £1bn over 10 years for access to Orkambi and other cystic fibrosis drugs in the pipeline. A more recent offer has been made by NHS England, according to a report in The Guardian, but the situation has not been resolved.

Rationing care

In another example the high cost of a drug used to treat hypothyroidism has led local NHS planners (CCGs) to restrict its prescribing. Patients are now paying out of pocket for the drug and travelling to other markets where it is much cheaper.

Reports in the Daily Mail highlight the difference in price of the drug - liothyronine, which costs £204 for a 28 day supply in the UK compared to just £1 for the same amount in Greece.

As a generic drug, liothyronine is not subject to any price controls in the UK. As it is the only product of its type on the market, there is also no competition to bring down prices.

As a result, Advanz Pharma was able to increase its price substantially without any restriction.

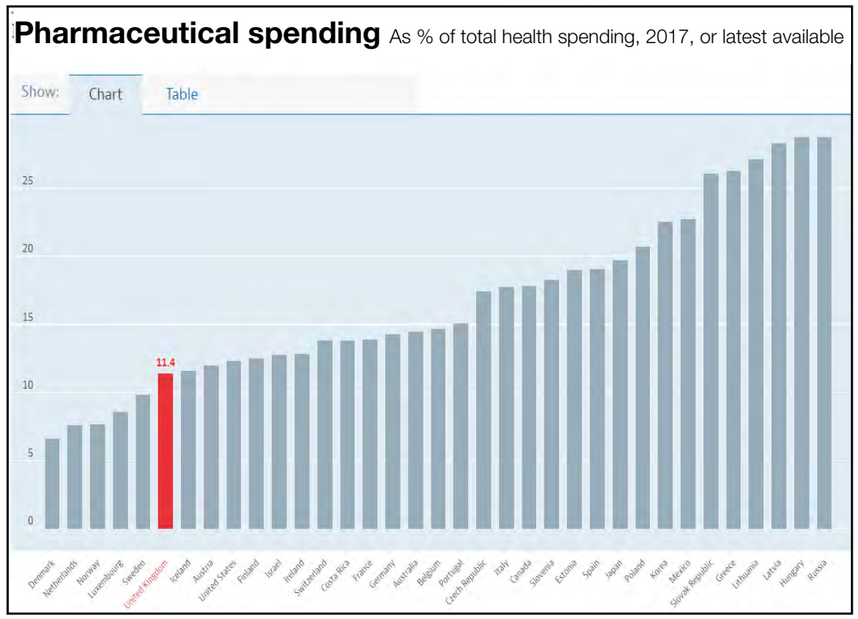
Over a period from 2009 to 2017, Advanz Pharma increased the price of a 28 day course from £5.15 to £258.19, up 1,605%.

As a result of the price rise, the prescribing of the drug was restricted to specialists and even in this situation, some patients were unable to get it on prescription due to restrictions.

In 2017, the Competition and Markets Authority (CMA) began to investigate the price hikes. Advanz Pharma maintains that it has not infringed competition law and all price increases were legal and approved by the Department of Health and Social Care over a period of ten years.

The CMA disagreed and has found that the company breached UK and EU competition law from at least 1 January 2009 to at least 31 July 2017.

Unfortunately for patients, despite the CMA's decision's the drug continues to be priced at £204 for a 28 day course, far higher than is acceptable to the NHS. The restrictions on prescribing, therefore, remain in place in many areas of the country.



creased by up to 2,600%.

The Competition and Markets Authority (CMA) has investigated these cases of dramatic price hikes. A change in law in mid-2017, however, should close the 'loophole' in the existing legislation that prevented the control of prices of unbranded generics supplied by companies that are members of the voluntary scheme for branded products.

What other ways does the NHS control prices?

New innovative products are assessed by NICE (National Institute for Clinical Effectiveness) for cost-effectiveness, using measures of improved 'quality of life' compared to existing therapies.

If NICE considers that the drug's effect on quality of life is not great enough to justify its price tag, then the drug is not recommended for use by the NHS.

The decisions by NICE often lead to discussions and negotiations with the manufacturers and the result is often a deal under which the NHS pays a lower price for the drug.

In particular, new medicines that NICE considers to be cost-effective, but which would cost more than £20 million in any of its first three years on the market are subject to price negotiations, in an effort to reduce the price. Unless a deal is reached, then NICE can delay access to the drug.

NHS England and individual NHS organisations also undertake negotiations with manufacturers for discounts, such as those based on volume use.

In November 2018, NHS England negotiated five deals with five manufacturers to get a cheaper version of one of the most expensive drugs used in the NHS, adalimumab, used to treat rheumatoid arthritis.

What happens when the drug pricing mechanism doesn't work?

Recent years have seen a number of situations where the drug pricing mechanism has failed and NHS patients have been unable to access certain drugs.

The failure to agree a price for Vertex's Orkambi, to treat cystic fibrosis, has resulted in many patients being unable to access what is the only treatment for this condition.

Vertex is refusing to reduce its price for the product, which the NHS says it cannot afford.

As already noted, in other cases, generic manufacturers have taken advantage of a loophole that existed for generic product prices and priced the product so high that the NHS has restricted its prescribing.

This has led to patients either not receiving the drug or buying overseas where the drug is much cheaper.

What will happen to drug prices post Brexit?

Drug prices and costs for the NHS will inevitably rise sharply under a no deal brexit scenario, according to the Nuffield Trust, which has investigated the scenario using data and reports from multiple sources.

The estimate was produced in November 2018, but the scenario still holds if we leave without a deal in October.

Other versions of Brexit will also increase the price of pharmaceutical products but by varying amounts.

According to the Nuffield Trust, a no deal Brexit will increase the cost of unbranded (generic) drugs by £830 million and branded drugs by £920 million by the end of 2019/20.

Overall, the cost to the NHS is estimated to be £2.3 billion by the end of 2019/20.

Some of these increased costs have already happened due to the effect on prices of the drop in the value of sterling after the EU referendum.

Mark Dayan estimates that this seems to have added around £500 million to the NHS trust deficits in 2016/17.

IEA pamphlet argues social care should be model for NHS

Anti-social model for social care – and NHS

What the (research) papers say

John Lister

A new pamphlet ***Integrating Health and Social Care – State or Market?*** was published by the Institute for Economic Affairs (IEA) with a flourish last month, but comes up with little that is new or particularly profound.

It reminds us that the IEA, a so-called "think tank" is really nothing more than an obscurely-funded right wing lobby group.

Perhaps the most surprising thing is that while exploring the problems of "integrating" the NHS (funded centrally through taxation, free at point of use) with social care (funded through local government, subject to means-tested charges), the IEA holds up the market-based, heavily privatised, and largely dysfunctional ***social care system*** as the model.

Pamphlet author Philip Booth gleefully celebrates the chaotic jumble of organisations involved in social care, and argues:

"In order to achieve meaningful integration, we should make the health sector more like the social care sector so that there is more pluralism in provision and financing."

He goes on to set out the tortured logic of achieving 'integration' through separation and competition: "Providers could then compete on the basis of how they integrated different aspects of care."

Underlying this confused approach is the IEA's visceral hatred of planning and public ownership, and veneration of competition and markets – without troubling the reader with any evidence to demonstrate the benefits of these mechanisms, which have failed even more spectacularly in social care in England than they have in the NHS since the 1980s.

NHS model rejected

Prof Booth is appalled at the idea of integration on the NHS model, or even the much less specific parallel development proposed by the Labour Party in 2017 when its manifesto called for a properly funded National Care Service.

In Booth's view the key factor has to be a competitive market:

"The creation of a National Health and Care Service would involve ***rejecting the most important mechanism*** [i.e. competition] ***for ensuring the efficient use of resources*** and determining how health and social care should be provided and integrated." (p10, emphasis added)

"In order to achieve meaningful integration, we should make the health sector more like the social care sector so that there is more pluralism in provision and financing."

In passing the pamphlet does highlight a few interesting figures and the continued (poorly publicised) existence of "Continuing Healthcare" (CHC) rules.

These rules require the NHS to provide full funding to cover a package of care provided outside of hospital that is arranged and funded solely by the NHS for individuals aged 18 years and older who have significant ongoing healthcare needs.

Rising cost of CHC

While Prof Booth chooses to highlight the proportion of people turned down for this support, the National Audit Office in 2017 noted that "In 2015-16, almost 160,000 people received, or were assessed as eligible for, CHC funding during the year, at a cost of £3.1 billion." This spending is projected to rise to £5.2 billion by next year.

This is interesting, and may be news to many people who assumed that social care consisted of bundling understandably unwilling older people into poor quality nursing homes – while compelling them to sell their houses and liquidate their savings to pay for it.

However it has little or no bearing on Prof Booth's main line argument for markets and competition as the solution.

"Individuals could combine insurance with paying for other services out of pocket or with care provided by family and friends."

He moves on to two seemingly obligatory cursory – and again largely irrelevant – chapters on technology before moving towards the subject matter that most interests him. But even here there is little of any weight.

Eventually, on page 22 comes a sweeping assertion designed to shut us all up, spelled out in one gigantic 78-word sentence:

"Even if the contestable ideas of those who support significant state intervention in the process of innovation are accepted, there is no evidence that nationalising and centrally planning the entire system of provision of a service and determining the structure in which it is delivered from central government will provide an environment conducive to innovation in terms of either the integration of methods of delivery of different aspects of health and social care or the adoption of innovations." (p22)

It's true, of course. **There is no evidence of this, because nobody has ever attempted the type of centralised integration he is describing.**

Nor, therefore, is there any evidence it would ***not*** work.

Scandinavia

But there is good evidence in Scandinavia, where both health and social care are run as predominantly public services by the same local councils, that their system works much better than depending, as in England, on the shambolic array of poor quality private and voluntary organisations that now deliver most social care.

More to the point, Prof Booth produces no evidence at all to prove his own point, and show that it is possible to use competition to drive integration.

The final chapter, "conclusion and policy proposals" reveals that the real motivation behind the IEA's contorted thinking is its commitment to "social insurance models for healthcare which could then be extended to social care according to the preference of the insured." (p24)

Booth's bottom line is returning the NHS to a pre-NHS insurance-based system, with the prospect of top-up charges for health care as well as the charges many already face for social care:

"Individuals could combine insurance with paying for other services out of pocket or with care provided by family and friends." (p25)

This might delight the tobacco companies and neoliberals who fund the IEA, but it won't enthuse many voters.

THE lowdown

Health news, analysis and campaigns.
NUMBER 5, June 22 2019

Informing, alerting and empowering NHS staff and campaigners

Bradford 97% vote for strike to stay NHS

Over 200 UNISON members at a Bradford Teaching Hospitals Foundation Trust – 97% of those voting – have voted to take strike action next month amid fears over "backdoor privatisation" of some of its services.

UNISON balloted its 313 affected members after the Trust unveiled plans to set up a wholly owned subsidiary company – securing a 70% turnout, and recruiting another 37 members.

The Trust plans to transfer around 600 staff from its estates, facilities and clinical engineering departments into the new company, but denies it is privatising services.

UNISON Regional Organiser Natalie Ratcliffe was clear:

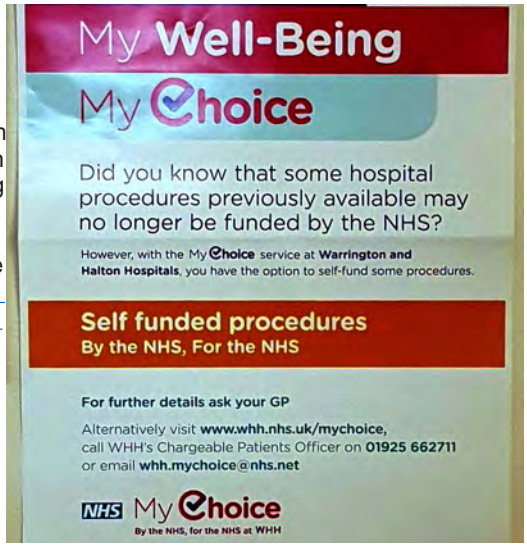
"This sends a clear message to the Trust that members are angry about these proposals. They clearly want to stay employed within the NHS to ensure they retain NHS conditions of service - and

(cont'd page 2)

Warrington warning

John Lister

Under the supremely inappropriate label of "My Choice," Warrington and Halton Hospitals Foundation Trust has decided to cash in on frustration at the growing list of treatments excluded from the NHS by cost-cutting CCGs in Merseyside and Warrington, and launch its own private NHS patient service.



There are fears that this is the increasingly commercial face of the NHS that is emerging from almost a decade of austerity on funding, and six years of legislation that urged Foundation Trusts like Warrington to make up to 50% of their income from private medicine.

Patients whose painful and debilitating health problems are now branded as "Low Clinical Priority" by commissioners, despite their proven value, can now nonetheless purchase the operations for cash up front from an NHS trust, which congratulates itself on its "affordable self-pay service," which charges "the local NHS price, previously paid for by commissioners."

Now – just as it was before the NHS was founded – patients who can afford it are urged to stump up the cost of treatment themselves, while for the many who can't there is not even a shrug.

The trust's website boasts that whereas My Choice was originally created in 2013, "the service has been significantly extended to include the large number of procedures no longer available on the NHS". It obligingly offers an extensive price list, including Hip replacements at £7,050; Knees at £7,179; and Cataracts at £1,624 each; as this is finalised the Mirror has just found an additional price list quoting up to **£18,000** for a hip operation.

Chief executive Mel Pickup says: "Procedures of low clinical priority do not mean low value to our patients, and we are pleased to be able to make a large number available at a really affordable price, at their local hospitals."

But this is not a Private Patient Unit. Patients are warned not to expect any special treatment: they are simply paying for NHS treatment that was once free.

"There are no private rooms and they will join the same waiting list as NHS patients. The major benefit is access to outstanding NHS treatments at a fraction of the cost of those undertaken by private providers."

It may not be long before other NHS trusts in the area and elsewhere in the country are following the Warrington model, excluding large numbers of elective treatments from the NHS for those without the money to pay.

The same long list of 71 excluded services has been imposed by **all seven** CCGs in Merseyside and Warrington, under the pretext of helping to "reduce variation" of access to NHS services in different areas ("sometimes called 'postcode lottery' in the media") and "allow fair and equitable treatment for all local patients."

To promote this massive shrinking of NHS cover as "My Choice" adds insult to injury.

Anyone accessing the service would choose for the NHS to pick up the tab rather than fork out themselves, and be told that by paying out thousands of pounds they are enabling the Trust to "make use of spare capacity and generate additional income to support our other services."

Campaigners are urging local MPs to step in and hold the CCG to account, and call for normal NHS services to be resumed.

Questions also need to be asked of the Trust's board of governors whose sanction is needed before such policies are implemented – and the so far silent NHS England and Health Secretary Matt Hancock, on why they are conniving at, or driving such an erosion of the NHS.

IN THIS ISSUE

Has NHSI given green light for more WOSs?

John Lister

The new round of proposals by NHS trusts and foundations to launch "wholly owned subsidiaries" comes after a series of strikes and battles last year challenged and defeated similar moves, most conspicuously at Wrightington Wigan and Leigh FT, where a succession of strikes eventually forced a change of policy.

In the late summer NHS Improvement, seeking to avoid further bruising clashes, announced there would be a review of the guidance issued to trusts on how to carry out such changes, and urged a pause in any further creation of subsidiaries.

By November, fresh guidance was published, which was seen by the unions as putting fresh hurdles in the way of trusts seeking to hive off their staff. The document stated that it was outlining

"a new framework that changes the way subsidiaries are reported to and approved by NHS Improvement from 26 November 2018."

But it also rather ominously went on:

"This framework strikes a balance between assuring us [NHSI] and respecting NHS freedoms and the ability of the NHS to innovate."

Indeed the tone is almost apologetic:

"We recognise that this updated approach increases the regulatory burden on some providers and we commit to reviewing the approach after one year to consider whether it is still appropriate and proportionate." (1.3)

The focus of the new guidance was on the obligation of each trust to produce a convincing business case, which "must demonstrate to the Secretary of State that the subsidiary is income generating" (1.2). Up to now business cases have been of poor quality, and little more than flimsy fig-leaves to conceal a hope of escaping VAT costs by establishing companies that can claim exemption.

The powers of trusts to set up such companies are based on legislation and guidance brought in by the New Labour government back in 2006. This stipulates that an income generation plan

■ must be profitable and provide a level of income that exceeds total costs…

The fact that new proposals are being pushed forward now, suggests the plans have been rubber stamped by Matt Hancock.

■ the profit made from the scheme … must be used for improving the health services

■ and the goods or services "must be marketed outside the NHS."

The guidance emphasises that "[Services] being provided for statutory or public policy reasons are not income generation" …

"the general legal power of NHS trusts to do anything that appears necessary or expedient in connection with their functions does not allow them to form or participate in companies for the purposes of core NHS healthcare provision. Trusts should not seek legal advice at the public expense on this issue." (2.1)

It also refers to more recent DHSC 2017 guidance and Treasury advice which make clear that:

"tax avoidance arrangements should not be entered into under any circumstances. We expect all NHS providers to follow this guidance when considering any new arrangements or different ways of working. … trusts should not spend money on private sector consultancy support in the development of tax avoidance arrangements as this represents active leakage from the healthcare system."

However the NHSI guidance is very tentative in spelling out what will be done where these principles appear to be breached. In lesser cases, "we request evidence in the form of a certification that the parent trust board has satisfied itself in relation to key areas of risk." This certification "should be submitted to and agreed with us before the trust enters into any legally-binding arrangements in relation to the subsidiary transaction."

Weak language like "requests" and "should be" implies little commitment to restricting trusts' actions.

In more serious cases "we undertake a further detailed review".

Despite the weak language it is clear that creating subsidiary companies currently requires the consent of the Secretary of State. And if the NHSI review panel rates the risk of a proposal as Red rather than amber or green "we can use our regulatory powers to stop the transaction if required" (p12).

So the fact that three new proposals are being pushed forward now, despite the opposition of staff, suggests NHSI has given them a green or amber light and the plans have been rubber stamped by Matt Hancock.

The government and NHSI have not learned the lessons of last year's strikes and confrontation – and are headed for more, similar confrontations – yet again making a nonsense of NHS England's rhetoric earlier this year about "integration" and seeking to scrap the sections of the 2012 Act which require competitive tendering.

Action against hiving off support staff

(Continued from front page

remain part of the NHS 'family', as the Trust describes its employees."

"The Trust have said they will guarantee that these members will have their pay and conditions for up to 25 years. Our members see that this is a promise that can be very easily broken."

Meanwhile in Birmingham, about 40 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) will strike for three days on 24-26 June after a 92% vote for action against being transferred to Summerhill Services Ltd from 1 July.

Unite regional officer Frank Keogh said: "This unpalatable transfer will strip our members of their status as NHS employees and is a part of the accelerating backdoor privatisation of the health service. Ultimately, it will lead to salami slicing of patient services. Unite is disappointed that trust bosses want to push ahead with their plans, despite the overwhelming opposition of the workforce.

"We are strongly against the formation of these entities which, we believe, could lead to a Pandora's Box of Carillion-type meltdowns – with adverse knock-on effects on patient services and jobs."

About 1,000 NHS housekeeping, estates management, equipment maintenance, catering, procurement and security staff at Frimley Health NHS Foundation Trust could also face being transferred to a wholly owned subsidiary (WOS). The Frimley trust provides NHS hospital services for about 900,000 people across Berkshire, Hampshire, Surrey and south Buckinghamshire.

More beds are needed - Stevens

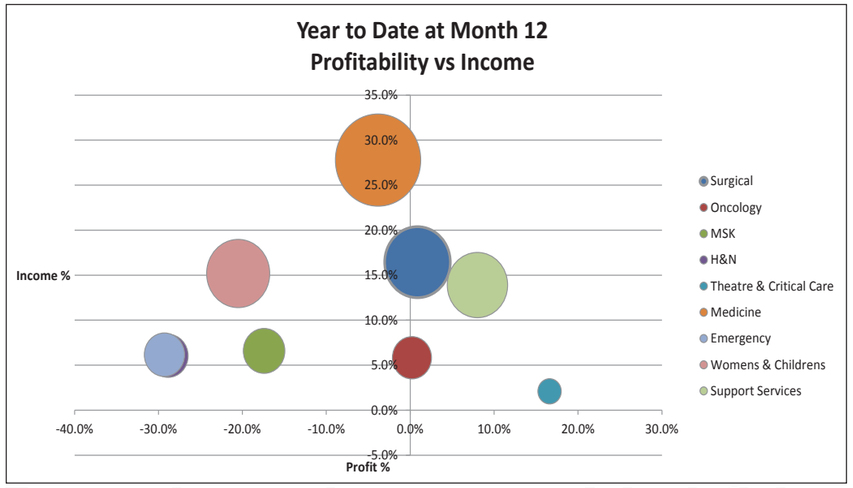
After more than a decade of relentless pressure to reduce numbers of front line hospital beds there was a first glimmer of common sense from NHS England chief Simon Stevens speaking at the NHS Confederation conference on June 19.

According to the HSJ report, Stevens finally stated openly that NHS hospitals' bed stock was "if anything, overly pressurised" and in need of "increased capacity".

The change of line at the top follows lobbying from NHS Providers, the trusts' most energetic advocates, and from professional bodies including the Royal College of Emergency Medicine which has seemed to be ploughing a lone furrow in raising this demand.

However accepting the need for more beds is a long way from delivering any increased number of beds, especially given the desperate shortage of NHS capital, highlighted again this month by NHS Providers (See aso page 5).

And a change of line by NHS England does not guarantee any change of attitude from bone-headed CCGs whose commissioning decisions have been one of the factors driving the reduction in beds since 2013.



Trust paints a picture to explain deficits

Unusually revealing figures in the end of May Board Papers for the troubled Shrewsbury and Telford Hospitals trust make clear that the trust as a whole is running at a loss:

"At month 12 the overall profitability for the Trust was 7.25% loss."

This cryptic comment is followed by a bubble chart, placing coloured bubbles that show the relative size of income from various specialist services on a scale that ranks them according to whether the service is profitable or loss making.

Medical specialities are by the largest loss makers with the bulk of services running up to 10% in the red, although women's and children's services are another large specialist area running even deeper in the red zone, with deficits of 15-25%.

Emergency services, a relatively small portion of income, generate a higher level of loss, with costs of delivering the service outstripping the tariff payment by around 30%. Musculoskeletal services run at a 15-20% loss.

Cancer services appear divided down the middle with half losing and half in surplus, surgery is two thirds in the profitable zone, but delivering no more than 5%.

Theatre and critical care services deliver consistent surpluses of 15-18%, but are small in scale.

So overall it's clear that this hospital trust would not be a going concern anywhere other than in the NHS. Two obvious conclusions:

● trusts like this will never be seen by US health corporations as potentially profitable targets to take over:

● and trust deficits are driven by serious underfunding of these core services – and they cannot be ended without brutal cuts in core services that would inevitably cause a major public outcry.

Hancock to face the music on charges

Matt Hancock has been summoned to appear before the Commons Health and Social Care Committee to explain his refusal to provide it with information.

The Committee is keen to make its own assessment of the Government's review of NHS overseas visitor charging. Back in January, it wrote to Hancock asking to see a copy of the review of amendments made to the NHS Overseas Visitor Charging Regulations in 2017.

Then Health Minister Stephen Hammond had made a written statement on this before Christmas, but the Committee had not seen the full review or the evidence provided to it.

Hammond's statement claimed that the review showed "no significant evidence that the 2017 Amendment Regulations have led to overseas visitors being deterred from treatment or that the changes have had an impact on public health".

The Committee wanted to make its own judgement on whether or not this was the case.

However Hancock's reply argued that he could not publish the review or the evidence because they contained "confidential information" from "interested stakeholders" which was submitted on the basis it would not be published.

Hancock has now been "invited" to account for his refusal to provide the information. It seems like an invitation he can't refuse.

The Committee responded requesting the evidence be supplied in confidence, along with the report, and offered to consider what sections might need to be redacted if it were published

Once again but Hancock refused to supply the information required.

The Committee has now states that it considers this refusal to be "contrary to the Government's commitment to being "as open and transparent as possible" with select committees", and in violation of the "presumption that requests for information from Select Committees will be agreed to".

Hancock has now been "invited" to give evidence in person on Tuesday 25 June, to account for the refusal to provide the information. It seems like an invitation he can't refuse.

And with the government claim so much out of kilter with the Royal College of Physicians and many medics and health professionals arguing the negative effects of the Charging Regulations, it seems likely he will have a hard time persuading the Committee that the 'review' was not just a cosmetic exercise.

NW London plan for mega CCG – ignoring local needs of 2.2 million people

John Lister

Just weeks after Health Secretary Matt Hancock and NHS England finally scrapped their long-running efforts to reconfigure hospital services and close Ealing and Charing Cross Hospitals, North West London health chiefs might sensibly have stayed quiet for a while, or even better offered an apology to local people for the money and effort wasted since 2012.

Instead they have already floated another unpopular plan.

This time they want to merge all eight CCGs in NW London into one mega CCG covering 2.2 million people and a patch stretching from Heathrow Airport to the middle of London, and from Putney to the M25.

The very notion of this as being in any way "local" or responsive to communities within this large area is laughable. It is very different indeed from the verbal commitment to localism that was used to sell the 2012 Health and Social Care Act, which set up the CCGs, and remains the legal framework of the NHS.

In fact it seems that a major attraction of the merger is likely to be hopes of being able to push through controversial plans by outvoting any CCGs and local boroughs which disagree, as NW London health chiefs tried to do with their "Shaping a Healthier Future" (SaHF) project until it was belatedly killed off.

Even at a time when other CCGs have been merging, its 2.2 million population would make NW London CCG an enormous monster, with more than double the population of the Devon CCGs that merged last year, and 1 million more than Birmingham and Solihull.

The paper arguing the case for the merger predictably cites the NHS Long term Plan, which vaguely called for each Integrated Care System to relate to a single CCG.

NHS England guidance

But it conveniently ignores specific NHS England guidance on CCG mergers that has been published since the Long Term Plan, and it's plain to see from the characteristically evasive language they use that the CCGs cannot answer many of the key issues raised in that guidance.

The guidance stresses that NHSE alone has the power to agree or reject an application for a merger, and there is no right of appeal. It is supposed to seek evidence on the extent to which the proposers have has sought the views of local authorities and other relevant bodies, "what those views are, and how the CCG has taken them into account". (p8)

In addition NHS England calls for evidence on

"the extent to which the CCG has sought the views of patients and the public; what those views are; and how the CCG has taken them into account;"

Since the track record of NW London CCGs on seeking and taking on board any critical views from local authorities or the public was appalling throughout the long-drawn out effort to push through SaHF – for which they have still not apologised or been called to account – there is little reason to suppose they will do any better now.

A major attraction of the merger is likely to be hopes of being able to push through controversial plans by outvoting any CCGs and local boroughs which disagree

Indeed the insistence on pushing through those plans led to two of the eight boroughs, Hammersmith & Fulham and Ealing, refusing in 2016 to support the Sustainability and Transformation Plan which mirrored the SAHF proposals.

That's why on page 6 of the document the CCGs state that the health and care system in NW London comprises 30 organisations including only six local authorities. On page 8 they concede that the area includes eight local boroughs. However at no point is this discrepancy discussed: instead the document claims evasively that the NHS

"will need to be clear about the strategic role of the integrated care system, operating at NW London level, and how we will work with our local authority partners in integrated care partnerships at borough level." (p8)

Councils left out?

Are Hammersmith & Fulham and Ealing included as "local authority partners" – or ignored?

The document predictably argues that a mega-merger could save money on admin costs, while downplaying any possible loss of jobs for CCG staff and claiming that they would retain "a strong and visible local representation in each borough".

But given that the entire operating cost of all eight CCGs is admitted to be no higher than £5.4m a year, £680,000 per CCG, even scrapping all of them completely would save just 0.2% of NW London CCGs' £2.9 billion combined budget. If this microscopic saving comes at the expense of any real accountability to local communities it's a poor trade-off.

There are many more weaknesses that could be highlighted in the 24-page document: but the biggest flaw of all is that it fails to address any of the key questions raised by NHS England's guidance, which states (page 10):

"The existing CCGs must demonstrate how the merger would be in the best interests of the population which the new CCG would cover. This is particularly important in any case where the boundary of the proposed new CCG is not coterminous with local authority boundaries.

"In all cases, in line with the legal requirements, the existing CCGs must demonstrate in their application that they have effectively consulted with the relevant

Will NW London CCG merger leave out both Ealing and Hammersmith & Fulham councils?

local authority(ies) regarding the proposed merger, record what the local authority(ies)' views are, and what the CCGs' observations on those views are. "They should also show how they have/will put in place suitable arrangements with local authorities to support integration at 'place' level (population of between 250,000 and 500,000)."

Nor do the CCGs appear to have answers to questions they themselves raise in the document, such as:

- What safeguards would a single CCG need to ensure it was responsive to local needs?
- What considerations should there be about a single CCG governance arrangements?
- How do we get a strong public voice into a CCG at NW London level?
- How do we ensure that the local voice is strengthened?
- The local partnership between health and local authorities will be key to delivering the outcomes the NHS Long Term Plan – how do we ensure this is most effective?
- What level of integration is appropriate and achievable? (p12)
- How will we engage with patients/public at local level?
- How would patients and residents be involved in decision-making?
- How should we maintain local accountability?" – p15
- How can we maintain staff morale and retention through this period of change? (p17)

How indeed? With more questions than answers, and a track record of indifference to local views, it would not be surprising if a groundswell of opposition to this merger plan emerged in NW London – inspiring similar challenges elsewhere, including the equally half-baked plans across the river to merge six South West London CCGs into one.

Cash cuts make a nonsense of NHS Long Term Plan

John Lister

The NHS Long Term Plan published just six months ago is already in shreds, undermined by impossible targets, the chaos in government and the continued austerity squeeze on both capital and revenue budgets.

The plan contained over 60 uncosted commitments to service improvements: but now the possibility of implementing any of it has been thrown into question, with unanswered questions over capital and revenue funding. It noted, for example that:

"The NHS will use its capital settlement to be negotiated in the 2019 Spending Review in part to invest in new equipment, including CT and MRI scanners, which can deliver faster and safer tests." (p57)

The case for such improvements is clear. After decades of under-investment Britain has the lowest level of provision of such crucial diagnostic equipment of any comparable advanced economy. But the promised changes are again on hold.

First the HSJ revealed a letter to trusts in May, telling them to cut down the scale of their requests for capital funding – and therefore also constrain the scale of any new developments or facilities. Trusts were being too ambitious in their plans, reflecting "pent up demand for capital spending," and "This level of capital spend would lead to the NHS unacceptably breaching its capital spending limit…"

Limit FT spending

NHS England and NHS Improvement were also seeking legal powers to limit capital spending by Foundation Trusts.

This followed warnings in March by the Health Foundation that annual capital spending in NHS trusts had fallen by 21% between 2010/11 and 2017/18 (see The Lowdown pilot issue #4). An increasing share of this was being frittered away propping up revenue budgets rather than invested, along with money from sale of assets:

"In 2017/18 almost two-thirds of the proceeds from land sales went into the revenue, rather than capital, budget." (p12).

Then in early June Liz Truss, chief secretary to the Treasury, told a Lords committee that the full spending review, scheduled for the end of this year, is "unlikely" to be completed until 2020.

And a few days later another HSJ exclusive flagged up evidence that the "extra" money the government claimed to have allocated for the first year of the Long term Plan was being "part funded by a fresh raid on cash intended for capital investment in the service's buildings and facilities".

Another £221m towards the cash increase for 2019/20 was to be taken from another "capital to revenue transfer", along with another £250m previously decided in the 2015 spending review.

The HSJ quotes Sir Robert Naylor, whose controversial plan to generate capital investment in the NHS centred on a rapid sell off of "surplus" land and assets, now insisting that "We simply have to stop doing this because we've been starving the NHS of capital funding for decades."

Backlog

The Health Foundation has warned of the consequences, pointing to growing backlogs in maintenance.

The recent scandalous state of operating theatres in Oxford University Hospitals Trust's once prestigious John Radcliffe Hospital underlines the scale and impact of this neglect. The CQC has taken urgent enforcement action for the Trust's "failure to provide safe care and treatment," after finding that among other failures:

"The environment was not always suitable for services provided. Areas in some of the theatres and wards were damaged and in need of repair and posed potential risks to patient and staff safety.

"Staff in the main theatre department had become disheartened that the refurbishment had not happened and had accepted the environment they worked in was substandard. Risks were not adequately reflected on the risk registers."

The HSJ quotes Joshua Kraindler, economics analyst at the Health Foundation, warning that:

"the capital budget is, in real terms, the same as it was in 2010-11 and as a result, capital investment per NHS worker continues to fall. The funding environment is also leading some trusts to abandon long-term transformation projects due to the uncertainty of capital funding.

"At the same time, there is a rising maintenance backlog of £6bn, which is now larger than the annual capital budget and half of which is rated as high and significant risk."

If the current cash limits continue, some key parts of the NHS could literally break down and fall apart.

Early mental health interventions for young people don't go far enough

Hannah Flynn

The Government's plans to train teachers to spot the signs of mental illness in their pupils are "little more than a sticking plaster", says the National Educational Union.

Any genuine strategy to tackle mental health problems in young people should include efforts to reduce poverty and inequality and reverse NHS and school budget cuts, suggested Dr Mary Bousted, Joint General Secretary of the NEU.

Responding to Theresa May's announcement that the government will improve mental health training opportunities for teachers she said:

"Schools need strong pastoral systems, but teachers cannot cover for the cuts to mental health specialists. Recognising the early signs is important but timely routes to appropriate professional treatment is essential.

At the moment referrals lead to long waiting times – children and young people should not have to threaten or attempt suicide before accessing CAMHS".

Social workers and healthcare professionals are also set to be given more opportunities to access better mental health training as part of new policy to improve early intervention and prevention announced by the outgoing Prime Minister. NHS staff will have access to suicide prevention training.

This latest policy announcement echoes that of Jeremy Hunt's promise while he was heath secretary in 2017 to put a mental health lead in all schools by 2025.

Yet, chronic cuts to mental health services, alongside the impact of austerity policies on schools, families and local authorities since 2010 have resulted in a mental health care crisis within the NHS which successive health secretaries have repeatedly noted, but failed to meaningfully tackle.

A young people's crisis

Though the well documented crisis in mental health care affects people of all ages, mental health services for young people in particular have failed to keep up with demand.

This is in part due to an increase in demand in recent decades as admissions to hospital for self-harm have almost doubled since 1997, and self-reported mental health conditions among young people have increased six-fold in England since 1995.

While health care professionals must be at the forefront of treatment, teachers have long felt under-resourced in this area. A recent survey of teachers by charity YoungMinds highlighted 84 per cent of secondary school teachers have taught a pupil they believe self-harms, and 77 per cent of teachers did not feel they had sufficient training on children and young people's mental health.

Nearly half of pupils do turn to teachers for help when struggling with their mental health, figures from NHS Digital in 2018 reveal.

The NEU had been calling on the Government to put children's wellbeing at the centre of education policy for some time, Dr Bousted continued, but "the 'exam factory' culture of testing, driven from Whitehall, is one significant cause of anxiety and low self-esteem among young people," she explained.

Staffing slashed

Yet, while demand for mental health services is high and rising, cuts and austerity have meant that there are even fewer services than ever before for children and young adults to access.

Over 20,000 roles were unfilled in the mental health sector in September 2018, with up to 2,000 staff leaving a month, figures from the Department of Health and Social Care showed. This is despite Hunt's promise in 2017 to deliver 19,000 more mental health staff by 2021.

Nurse numbers have been particularly hard hit, with the scrapping of the bursary, uncertainty over Brexit and increasingly challenging working conditions all playing a role in the current 14.3 per cent vacancy rate for mental health nursing roles across England.

This represents a 13 per cent reduction in the total number of mental health nurses across all settings since 2010. A 19 per cent reduction in the total number of school nurses in England as well, doesn't help.

Catherine Gamble, Royal College of Nursing Professional Lead for Mental Health Nursing, points out that teachers already identify and support pupils with mental health issues, but notes: "It is vital, however, that there is sustained investment in mental health nursing to ensure those in need have access to the full range of treatments once mental health issues are identified".

This week the College said an additional £1 billion funding for nurses education was required at a minimum, if the Government was to recruit enough nurses to realise its NHS Long Term Plan.

Reduction in capacity

Even if there were enough staff to deal with the number of young people who need mental health services, it is unlikely the system has enough capacity to take them. The number of beds for mental health patients in England fell 30 per cent since 2009.

An overhaul of children's mental health services announced by Hunt in 2017 promised to slash waiting times for CAHMs to just four weeks from referral. Yet, an HSJ investigation last year showed hundreds of children were waiting more than a year, and over half of children referred to CAHMs were forced to wait 18 weeks.

What young people need

Early intervention for mental health is important, but similar to all other areas of health, it is useless if it is not the first step towards appropriate treatment.

Nick Harrop, Campaigns Manager at YoungMinds who have been campaigning for better early intervention for young people said: "We know from the young people we work with how hard it can be to access mental health support, and there is still a long way to go before help is available to every young person who reaches out.

"With rising demand, prevention and early intervention should be genuine priorities, and we need to see greater investment in community support beyond the NHS, so that young people can get the help they need when problems first emerge."

In numbers

84%
of secondary school teachers have taught a student who they believe self-harms in the last year

77%
of secondary school teachers do not believe they have had sufficient training on children and young people's mental health

35%
do not feel confident knowing how to support young people with mental health issues.

37%
do not feel confident knowing how and when to refer young people to Child and Adolescent Mental Health Services.

Figures from a survey carried out by charity YoungMinds of 3,257 secondary school teachers in August and September 2018.

Keep Our NHS Public and Health Campaigns Together are holding a mental health summit in September.

Move to privatise cytology screening for London patients

Paul Evans

The result of an open tender competition to provide Laboratory services to the NHS will see one of the nine lots awarded this week likely to go to a private company.

Health services laboratories LLP has been confirmed as the preferred bidder and commissioners are expected to finalise the arrangements with the company.

The company is a for-profit partnership between The Doctors Laboratory - owned by Sonic Healthcare Ltd, an Australian clinical diagnostics organisation and two London NHS trusts – ULC and the Royal Free

Unions have already highlighted the threat to jobs as many of the existing units will close.

The tender was part of plan to centralise Cytology services and reduce the existing 46 laboratories to only nine. However, the process has already caused a mass exodus of biomedical scientists from the centres that were marked for closure.

The tender coincided with a wave of extra demand for screening tests in response to a Public Health England advertising campaign. Consequently, a huge backlog of samples built up with existing units understaffed and unable to cope with the extra demand

Delays of several months has caused unnecessary anxiety and a risk to health and has led the chair of the British Association for Cytopathology Alison Cropper to say that the cervical cancer screening service is 'in meltdown'.

Health secretary Matt Hancock has ignored calls from unite and the union who represent many of the staff affected to abandon the procurement.

Unite national officer for health Colenzo Jarrett-Thorpe said:

"Losing hundreds of skilled, highly qualified professionals from the NHS, thus eroding the science and technical skills base in the NHS, is to be deplored.

"The impact on thousands of women, who rely on cytology screeners to analyse cervical smear tests, is a huge concern."

It comes at a time when NHS England leaders are already under pressure to stand by their commitment to abandon the enforced tendering of NHS services, which they made back in January.

In a parallel tendering exercise, world renowned NHS cancer screening services in Oxford are being handed over to private firm Inhealth, despite an all-party appeal to ministers. However, a public campaign supported by MPs, councillors and local doctors is continuing to raise questions about the logic of the decision and highlight threats to patient care and the wider service.

The tender was part of plan to centralise Cytology services and reduce the existing 46 laboratories to only nine

Solutions to NHS staffing crisis delayed for Tory leadership campaign

Paul Evans

The NHS has been waiting for a workforce plan to layout the solution to its serious crisis in staffing. Interim plans have finally been published, but news that the government spending review is "unlikely" to take place this year will put a brake on further progress.

When NHS England published its 10-year plan for the NHS back in January 2019 plans for extra staff were missing - but promised later. It dented the credibility of the announcement and the absence of a work force plan was put down to a lack of agreement about funding.

An update from Treasury secretary Liz Truss to a Parliamentary committee has confirmed that the comprehensive spending review will likely be postponed because of the distraction of the Tory leadership campaign, which will come as a blow to NHS leaders as it was widely expected that this was the opportunity to resolve the funding issue.

It comes in week when the Health Foundation have hammered home the message that current funding arrangements will not be nearly enough to carry out NHS plans. They calculate that a further £8 billion needs to be spent over the next five years.

This is on top of the £20.5 billion, announced last year that did not factor in the cost of training and recruiting new staff.

The interim workforce document published by NHS Improvement sets out priorities and puts some targets in place, to start to address the giant 100,000 short fall in NHS staff, but reaction to the plan has been mixed. NHS leaders question how much can be achieved without settling the funding issue.

"A good plan is a good start, but for this to be more than a piece of paper, it needs to be backed up with money and people," said Nigel Edwards, chief executive of the Nuffield Trust.

Shadow health secretary Jonathan Ashworth called the interim plan "thin gruel ducking the big challenges of how to solve an escalating staffing crisis because Tory ministers have refused to back up the plan with the cash that is so desperately needed."

The new Tory party leader is expected to be announced at the end of July just before MPs head off for the summer recess. Brexit will be the priority for the new PM, with a tight timetable.

Throw in the growing possibility that Parliamentary gridlock could lead to a general election later in the year and the NHS might be in for a long wait for the extra funding it needs.

What do the interim plans say?

The delayed Interim People Plan, authored by NHS Improvement, opens with some straightforward admissions.

"The culture of the NHS is being negatively impacted by the fact that our people are overstretched – this is evident from the 2018 NHS Staff Survey where more people have reported bullying, harassment and abuse in their workplace in the last 12 months"

The plan sets a target to raise nursing numbers by 40,000 by 2024… However the size of target has already been questioned by research that estimates the number of nurses needed will be nearer 70,000 by 2024

The report points the finger at NHS management, identifying that "workforce planning has been disconnected from service and financial planning." NHS boards are often distracted by operational and financial issues.

The authors remind us that another period of big change in the NHS has started, "We need different people in different professions working in different ways" and they echo the themes set out in the long-term plan, around new multi-disciplinary teams working increasingly outside of hospitals.

The overall challenge is complex; new staff must be recruited, ex workers enticed back and training quickly increased, but the report also acknowledges that factors like pay and the conditions in which staff work, will all need to be tackled.

But the report has been slow in coming out and admits that it can't publish "detailed, costed action plans" until after the comprehensive spending review.

It promises a stepped approach "to take immediate action in 2019/20 while we develop a full five-year plan"

For an NHS workforce that has endured truly testing times and has waited a long time for support from policy makers, this will sound like warm words, when most are desperate to see action.

Boosting staff numbers?

The report admits that "urgent" and "accelerated action" is required to fill nursing vacancies in primary, community and mental health sectors.

The plan sets a target to raise nursing numbers by 40,000 by 2024, using four approaches

- international recruitment by appointing lead agencies to co-ordinate the process
- ensuring more nurses enter training
- improving retention rates by placing a greater emphasis on career developing
- encouraging nurses back into the NHS with the promise of flexible working opportunities

However the size of target has already been questioned by research that estimates the number of nurses needed will be nearer 70,000 by 2024.

There are also no plans to reverse George Osborne's disastrous decision to stop paying nursing students' tuition fees and maintenance grants, which has led to a huge drop in those applying to be nurses – 31% fewer between 2016 and 2018, at precisely the time when the profession needed to boost its intake.

Workers from abroad?

Throughout its history the NHS has relied on foreign health staff. One in eight of current NHS employees are foreign nationals.

The health secretary Matt Hancock has himself called for another Windrush generation, but the suggestion runs against the strong desire of Tory Party supporters to see immigration fall.

The Observer reported that plans to announce a 5000 a year target of nurses from abroad were recently dropped. The proposal would be hampered by immigration rules that could barr more than 40% nurses as they would need to earn at least £30,000 a year.

Without staff, we have no NHS

"Even if you take all the actions that we could identify … the nursing gap is not going to shrink at all in the next five years without international recruitment."

Many rightly question the morality of a recruitment policy that could drain talent from countries that badly need it for their own development. However, Mark Dayan policy analyst at the Nuffield Trust think tank believes that the options are very limited.

"Even if you take all the actions that we could identify in terms of boosting nurses in training, preventing them from leaving at the same rate, the nursing gap is not going to shrink at all in the next five years without international recruitment."

He says that 5000 extra nurses a year would half the recruitment gap by 2023/24 but still leave a lot to do, but without it pressing issues around patient safety and treatment delays will remain

Better conditions?

Few will fault the plan's ambition of "Making the NHS the best place to work", but the much of the detail, money and urgency that is needed is still missing.

A national return-to-practice scheme - set up in 2014 is being expanded and a new marketing partnership with Mumsnet aims to advertise job opportunities and entice nurses that have left the NHS to come back to work.

A major staff engagement exercise will be launched this summer, led by new chief people officer Prerana Issar, to "create an explicit offer to staff" that will address their major concerns.

However urgent action is needed, to stem the flow of staff leaving the NHS. The turnover of staff is high, one in 11 NHS staff quit every year, staff sickness is 2.3% higher than the wider economy.

Tough working conditions, poor career development and low pay have combined to drive thousands of trained staff away from their NHS careers.

UNISON head of health Sara Gorton said:

"Holding on to staff is probably the biggest challenge facing the NHS. All workers across the health service need to know they're valued and must be given the right training opportunities to use their skills and experience to move into more senior roles."

No time should be wasted before dealing with the evident bullying problem in some workplaces or in vanquishing the resistance to achieving ethnic diversity in NHS leadership positions.

Working under pressure

Routine gaps in the workforce make it difficult to fill medical and nursing rotas.

The everyday pressures of working long hours, sometimes beyond the limits of safety, are still widely felt amongst staff.

Over half work unpaid overtime very week. Stretching beyond safe limits sometimes results in tragic consequences. Trainee doctor Hadiza Bawa-Garba was found guilty of manslaughter by gross negligence in 2015 following the tragic death of a six-year-old boy from sepsis on a night when she was looking after six wards of patients without supervision.

The case sent a strong message to NHS staff that you can pay a big price for shouldering the burden of systemic staffing shortages.

A survey of nearly 8,000 doctors found that 95 per cent were fearful of making a medical error and more than half feared they would be blamed for problems arising from failures in the system, a factor in many doctors not completing their training.

It is hard to escape the fact that NHS relies on its staff but without taking proper care of them.

It can be as simple as being able to get a warm meal even if you're working a night shift, or having somewhere to rest, but fundamentally the capacity of the NHS must rise before staff will feel less overworked.

New leadership?

NHS Improvement has promised to change the leadership culture. No time should be wasted before dealing with the evident bullying problem in some workplaces or in vanquishing the resistance to achieving ethnic diversity in NHS leadership positions.

Almost 30 per cent of NHS staff said they had been bullied by patients or their families in the past year, with 25 per cent reporting abuse by other workers.

Matt Hancock said he is "horrified" that NHS staff surveys revealed 12 per of staff felt discriminated against, rising to 24 per cent for BME staff.

Dido Harding, chair of NHS Improvement, which is leading the work on the People Plan, said it was clear that there were "challenges" with staff.

She said "I want front-line NHS staff to know we have heard their concerns about the pressures they face and we are determined to address them.

"The NHS needs more staff. But that, on its own, is not enough. We need to change the way people work in the NHS and create a modern, caring and exciting workplace."

France: emergency staff fight for more beds, staff and salaries

John Lister

The French health care system is regularly touted by right wing commentators as superior in its performance to that in England – ignoring its considerably increased level of spending per head (€200 billion per year), superior availability of scanners and higher provision of beds.

But a major ongoing dispute in hospital emergency departments underlines the fact that inadequate staffing levels and funding can wreak havoc there too.

On June 10 emergency workers staged a national day of action, following on from strikes and protests which began in Paris back in March, and which have now reached to 95 emergency departments in hospitals across France. The strikes have been backed by French unions CGT, Sud and Force Ouvriere.

The strikers are complaining of funding cuts, a government reduction in the number of beds and a serious lack of medical staff leading to dire working conditions for emergency room staff.

The health ministry's figures show that from 2012 to 2016 emergency room visits in public hospitals (which make up the bulk of France's hospitals, and almost all of the emergency provision) increased by 12 percent, while the number of paramedics increased only by 5 percent.

The lack of resources has led to a mortality rate 9 percent higher than it would be in adequately resourced emergency departments, according to Christophe Prudhomme, spokesperson for the Association of Emergency Room Doctors, who warned last year that for patients in critical condition that number can reach as high as 30 percent.

François Braun, president of the ambulance workers'union said the French system of emergency care' has reached an unprecedented breaking point, as he issued the call for a five-minute walkout.

The stoppages have been restricted because it is illegal for emergency department staff to strike in France.

As a result their protests have taken various forms, with large numbers of staff taking sick leave to deal with 'burnout' after working excessively long shifts. In St Antoine hospital Paris, RFI reported 16 out of 19 staff members went off sick after having to work a marathon 18 hour stint the previous Saturday.

In Lariboisière hospital in Paris 65 percent of the emergency night team reportedly took sick leave shortly before their shifts were due to begin at 9pm.

But management have retaliated: hospital chiefs in Jura, eastern France sent gendarmes with requisition orders to the homes of healthcare workers, demanding they turn up for work.

Hospital chiefs in Jura, eastern France sent gendarmes with requisition orders to the homes of healthcare workers, demanding they turn up for work.

1.00am knock from police

According to an angry emergency doctor: "The police came to the door of a nurse at 1.00 am. She had already worked 72 hours that week."

Emergency staff say they are being forced to work long hours to compensate for staff shortages, and warn that this is putting patient care at risk. An investigation into the death of a 55-year-old patient a Paris hospital last December while awaiting treatment has found that the emergency department was overwhelmed with patients that day.

The emergency staff are demanding more beds, 10,000 more staff, and a €300 per month increase in pay. They have forced action from Health Minister Agnes Buzyn, herself a former hospital doctor, has refused to condone spurious taking of sick leave, but said that she "understands the impatience of emergency workers" as a result of the "unbearable everyday existence" they face.

She has announced five immediate measures to tackle the situation, including accelerating the renovation of dilapidated emergency department buildings, the creation of a bonus for paramedics who carry out duties normally carried out by a doctor, and the extension of another bonus which already exists for paramedics to cover more staff.

She has also asked MP Thomas Mesnier, who was previously an emergency doctor, and the President of the National Union of Emergency Services to come up with a plan to restructure the country's emergency services, with their proposals expected by November.

Privatisation, Secrecy – and Lies

RICHARD BOURNE argues that public bodies are not traders, and that most of their so-called business secrets should not be kept secret at all.

Campaigners against privatisation can rightly claim much credit for preventing the threats posed by the Health and Social Care Act ever being implemented. NHS England rhetoric around future NHS policy is now about removing the market and returning to policies of collaboration; no more compulsory tendering.

But some still don't hear the message. Campaigners must continue the struggle.

Thanks to vigilance and campaigning the vast majority of NHS services do not go through any kind of tendering or procurement. Only a small percentage (perhaps 8%) of core NHS services are placed with for profit organisations by commissioners and the increasing trend since 2006 has levelled off.

However some CCGs and commissioners of specialist services are still making plans to tender for 10 year contracts for NHS funded services.

And these figures do not include the outsourcing of support services by hospital trusts. Once again some NHS Trusts are trying to outsource services to make tax gains.

Those who campaign against outsourcing and privatisation often face a serious obstacle: we cannot get the information we need. Secrecy prevails, so we cannot show that what is said in public is simply not what was agreed in private.

The key to understanding what is planned will be in the Business Case.

Every NHS body contemplating a significant procurement must produce a business case, and that is the mechanism through which accountability is established. And the last thing most NHS bodies want is to be accountable.

Instead public bodies fully funded by us claim that in fact they are commercial bodies competing in a market and forced to protect their position by keeping everything secret, invoking "commercial confidentiality". They refuse to provide information about what they are planning to do, and more importantly why they are planning to do it.

Typically, a campaigner or staff representative picks up that there is a plan to outsource a service or to "reconfigure" and that there will have to be a procurement and competition.

So, you ask to see the papers relating to the decision, and the Business Case used to justify it. But the request is refused, so you resort to using the Freedom of Information Act.

But that takes a lot of time.

I have two cases in mind where the decision to refuse information was fought through every step of the process … and 18 months later in each case full disclosure was ordered. There was no apology; just grudging compliance.

It was eventually obvious that the reason for withholding information was actually because the business case was so poor it would have embarrassed the organisation.

There have been attempts to persuade NHS leadership (nobody knows which organisation does what any more!) to send out very clear messages – that:

- tendering and competition is to be avoided
- and if it is used then everything about the process must be open and transparent.

Part of the problem is of course the lack of funding. In many cases bringing services back into the NHS and avoiding outsourcing requires investment in the NHS to rebuild lost capacity. Sometimes the NHS cannot provide a service, so someone else comes in – but the answer is to build NHS capacity as an investment, not waste money on short term get arounds.

So for every procurement there should be a clear statement about what it would require to build NHS capacity as an option. Then some test of overall social value ought to apply, not just financial.

But this is useless unless we can all see the case being made and put our arguments forward.

Which comes back to commercial confidentiality – and lying.

Public bodies fully funded by us claim that in fact they are commercial bodies competing in a market and forced to protect their position by keeping everything secret

Information can be withheld if disclosure would or would be likely to prejudice commercial interests. Well, for a start, public authorities are rarely trading entities and their interests are rarely commercial.

But there is a limitation placed on this anyway. That requires that "the chance of prejudice being suffered should be more than a hypothetical or remote possibility; there must be real and significant risk".

This justification has to be spelt out objectively with facts if a request for information is declined. That is incredibly unlikely ever to be met.

In respect of the vital Business Case disclosure there is strong guidance anyway from 2008 which sets out what can and should be disclosed during a procurement. This makes clear that all vision planning and strategy documentation including the Business Case can be disclosed once the bid documentation has been issued. **Basically, the public has the right to know as much as the bidders!!!**

So information should be available before any decision to award a contract is made. The only things that are genuinely confidential are matters flagged as such by bidders, such as trade secrets – and even then a public interest test can overrule that desire for secrecy. Public bodies are not traders!

Yet while a few do publish the case in full on their web site – good for them – too many CCGs and Trusts routinely refuse to provide Business Cases even after contracts have been awarded.

It is time we stepped up the campaign to make sure NHS leadership who have so far been complicit in this secrect and decption make sure CCGs and Trusts act openly and transparently and stop hiding behind bogus confidentiality.

THE lowdown

Health news, analysis and campaigns.
NUMBER 6, July 6 2019

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 privatise 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.


Shutterstock.com

Evasive on privatisation – Hancock

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.

Local GPs had raised concerns about the plans

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".

IN THIS ISSUE

Gaps exposed in social care

Tens of thousands of older and disabled people are being denied basic support such as help with washing and dressing as a result of almost a decade of budget cuts and now the government's failure to get to grips with the escalating financial crisis in social care.

The Association of Directors of Adult Social Services (Adass) reveals this and many other grim facts in its annual survey, which notes that nearly a fifth of councils now admit the quality of life for people using care has got worse.

Adass says social care in England is adrift in a "sea of inertia" caused by years of budget cuts and Brexit-related Whitehall policy paralysis – now compounded by the Tory leadership contest: the promised Green Paper has been repeatedly postponed and seems unlikely to appear until after the next election.

While both claim to be committed to solving the crisis in social care, neither of the two candidates to be the next prime minister has promised any new money.

Age UK has previously warned that tightening eligibility criteria for council-funded social care have left 627,000 people – nearly 900 a day – have been refused social care since March 2017. Estimates suggest 1.4 million older people now have unmet care needs, an increase of 20% in two years.

Councils spend on average 38p of every pound they spend overall on adult social care – up from 34p in the pound in 2010, but more than a third of them overspent their adult social care budget last year, many covering the extra cost by cutting other council services.

■ From a report in Health Campaigns Together on the new **Reclaim Social Care** campaign.

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". was apparently being seconded to Nottingham STP, although this was quickly thrown into doubt.

It was obviously an unanticipated decision. After an unannounced visit the previous Friday by Prof Ted Baker, the CQC's Chief Inspector of Hospitals, Wright reportedly told a meeting of his consultants that all was well, and he was in it 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. Unusually, the Secretary of State's Independent Reconfiguration Panel (IRP) have required more evidence.

They are unconvinced by the clinical model put forward by SaTH that requires the closure of an A&E and downgrading of one of the two district hospitals.

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

The reason might also be that SaTH was given an inadequate rating by the CQC last autumn. 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.

We can assume that the CQC might be unhappy with the progress made.

The latest news on the maternity investigation will not have helped either. It has just been revealed that Donna Ockenden, leading a review of SaTH's maternity services ordered by the Secretary of State, is now investigating over 550 'cases of concern' including baby and maternal deaths.

That is over double the number of cases investigated at Morecambe Bay.

SaTH being found guilty and fined by the courts over an asbestos case is probably just the icing on the cake. But sacking the whistle-blower was probably not the most intelligent move.

Just after the fine was disclosed, it came to light that another building had to be closed for 6 months for asbestos removal – the building they spent half a million renovating last year. Just an oversight?

Shropshire Defend had called for Wright's removal. But it also has campaigned effectively on all the issues which might have forced him out. The Campaign provided significant material for both the CQC and maternity investigations provided by its supporters.

On Future Fit, the five-year battle has put the health bosses on the defensive time and time again. And the evidence provided has been sufficient for the IRP to halt the process at least temporarily.

It is not just in the acute sector that the Campaign has been successful. The CCG have removed proposed cuts to community hospital beds, closure of MIUs, and cuts to multi-disciplinary assessments of older people from their plans.

The reaction of a 600 strong public protest meeting in Ludlow, at which Philip Dunne, the local MP, was literally shaking as he tried to defend the health bosses, has eventually made them decide they could not risk putting these cuts out to consultation.

However, with the Shropshire health economy required to make £51.6 million cuts this year, the Campaign can only try to hold back the tide, without an increase in finance. The latest letter to the Campaign from Philip Dunne (who is Jeremy Hunt's campaign manager), shows the Campaign's political pressure is also becoming effective.

For the first time, he has admitted Shropshire needs 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 trust even prompted BBC social correspondent Michael Buchanan to comment that "I doubt there will be many involved in the provision of healthcare in Shropshire who will shed a tear over Simon Wright's departure,") has decided not to take up the job there. He is 'going to spend more time with his family' instead.

Campaigners like these will be heaving a massive sigh of relief as Wright departs

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

■ Based on an article by Pete Gillard, Shropshire Defend Our NHS, in Health Campaigns Together July 2019.

BMA votes to oppose racist NHS charges

The campaign to reverse reactionary legislation stemming from Theresa May's "hostile environment" to migrants has now gathered the support of almost all the professional bodies representing doctors.

In March the Academy of Medical Royal Colleges, covering all 24 medical royal colleges adopted a powerful statement rejecting the case for the charges and calling for the suspension of the regulations.

Now the BMA's 2019 Annual Representatives' Meeting has carried a motion (below) from Tower Hamlets which goes further and calls for the regulations and all charges to be scrapped.

The campaign has been led by Docs Not Cops and Patients Not Passports, and supported by Medact. Health Campaigns Together and Keep Our NHS Public have also supported vigorous protests in Liverpool, Bristol, Birmingham, Brighton, Cambridge and London.

The case has been forcefully made to refute cynical and hugely exaggerated claims by government and the right wing press that the charges are simply targeting "health tourists", and proving that the legislation is inherently racist, discriminatory, and contrary to NHS principles.

Health Secretary Matt Hancock has twice refused a call from the Commons Health and Social Care Committee to explain why the Department has refused to publish the outcome of its review of the charges, which apparently concluded that there was no significant evidence of overseas visitors being deterred from treatment or that the charges had had an impact on public health. On June 25 Hancock sent health minister Stephen Hammond in his place, who revealed under questioning that the review had not been on the impact of the charges since 2017, but on the more recent application of an amendment.

Hammond also admitted there had been no public consultation on the amendment, even though it transformed the "guidance" on checking eligibility for free treatment into a legal requirement to raise up-front charges

The "review," admitted Hammond, was carried out just six weeks after the change. Predictably (and conveniently for ministers facing questions in the house) it found little evidence of its impact. It is so flawed they have been determined to keep it from publication and even withhold it from the Committee.

Evidence continues to emerge of people being deterred from seeking treatment and inappropriately denied access to care.

Motion by TOWER HAMLETS DIVISION:

That this meeting notes that in a pilot to check eligibility for free NHS care only 1/180 people were deemed ineligible and:

i) this meeting believes that it 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) that 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.

Docs Not Cops

UNSETTLED

Notice in Out-Patient Clinic: "NHS treatment is only automatically free for settled UK residents"

Dear Doctor,

This patient is unsettled, an unsettled UK resident.
He is unsettled about the weather,
Clouds dubious with rain, processing from the West
Like a crowd of grey-suited mourners.
He is unsettled about what to say and what not to say,
And the language is often ambiguous.
He is unsettled by people always saying "sorry".
He is unsettled by the newspaper
Referring to him as a cockroach.
He is unsettled that no-one else seems unsettled
About his plight.
He is unsettled by unsettling notices in hospitals
Warning him not to be unsettled.

The patient would like to be settled.
Please advise how he can do this.

Plum £1bn contract set to go private

An undisclosed private firm is the front runner to snap up a £1 billion 10 year contract to run community services – at a time when NHS England has tried to persuade trade unions, campaigners, concerned politicians and the public that they are trying to limit competitive tendering.

This latest, very large contract is being tendered out by privatisation zealots in charge of the Bristol, North Somerset and South Gloucestershire CCG.

The secretive process has been dragging on behind the scenes since January despite repeated efforts by Bristol West MP Karin Smyth, to stop it and call the CCG to account publicly for its actions.

The name of the winning firm is still under wraps until September, and CCG chief executive Julia Ross said to the governing body meeting on July 2 it was "not a foregone conclusion" that the preferred provider would become the contract winner.

The secretive process has been dragging on behind the scenes

What is a foregone conclusion is that this new exercise in privatisation will continue behind closed doors. Moreover the track record of CCGs in carrying out "thorough background checks" does not inspire confidence, and this secretive CCG has given no grounds to believe their approach will be any more rigorous.

In the unlikely event of organisation with the top score being ruled out by anything discovered during background checks, the CCG would turn to the bidder in second place, whoever that might be.

Either way the public will be none the wiser, and the privatisation process rolls on.

Implementation Framework published for Long Term Plan

Stand by for new round of secret plans

John Lister

The new NHS Long Term Plan Implementation Framework document published by NHS England and NHS Improvement was published well after Treasury Secretary Liz Truss confirmed that the spending review, expected to be completed in the autumn, has been delayed by the chaos in the Tory Party, and will not now report until the new year.

NHS England's hopes of agreeing five year plans by the end of the year were all conditional on the outcome of the spending review deciding how much revenue and capital might be available. Until ministers' decisions are known, many NHS plans will remain no more than wishful thinking.

However this problem is simply ignored in the Framework, giving the document an immediate air of unreality.

Once again, as with Sustainability and Transformation Plans three years ago, the Framework sets out a hugely ambitious and probably impossible timetable for rapid decision making and top-down change.

Draft plans need to be submitted by 27 September and finalised by November 15 (p32) – so expect a repetition of the secretive process that hatched up 44 largely useless STP plans in 2016. The Framework sets out the approach through which STPs and Integrated Care Systems (ICSs) should create "five-year strategic plans covering the period 2019/20 to 2023/24."

Workforce

Despite having only the sketchiest of "interim" workforce plans so far in place nationally, 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 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 financial recovery plans for individual organisations in deficit against specified deficit recovery trajectories, with actions to achieve cash releasing savings including through the reduction of unwarranted variation and how they will moderate growth demand."

Local managers are required to guess the outcome of future government decisions: "Plans should set out capital investment priorities for capital budgets being agreed through the forthcoming Spending Review."

The Framework itself reveals that some of the so-called "priorities" in the Plan have now been elevated into "critical foundations" – which all areas must try to do at once.

This means a series of other priorities have been relegated to lesser importance, and effectively kicked into the long grass.

The priorities that have remained prioritised include **primary care and community services** (which are set to receive the largest allocations of additional funding up to 2023); **mental health** (receiving the next largest allocation of extra cash); **urgent and emergency care; cancer; increasing numbers of elective operations; 'personalised' care** (which always seems to be laid down in a one size fits all formula) and **digital primary care and reduction in numbers of outpatient appointments** – in line with the "digital first" mania in the Long Term Plan.

Sadly Star Trek's Dr McCoy's technologcal cures are fiction

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

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 serious discussion of restricting demand, urgent and emergency care, primary and community care, cutting out 30 million outpatient appointments and increasing provision of elective operations.

The requirement to expand elective services is also complicated by attempts to rein in spending 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 which exclude routine referral for cataract operations, hip and knee replacements and other proven effective treatments, are forced to think again.

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

In words the Framework commits to tackling inequalities: "System plans should demonstrate the key areas of inequality they will tackle and how additional funding is targeted" (p5)

In deeds, when Warrington & Halton hospital trust offered to allow patients who could afford it to pay for access to many "low value" treatments no longer routinely funded by local CCGs, Simon Stevens criticised the way they presented it rather than the two tier NHS they were threatening to open up.

Crisis response … or not?

In words the Framework commits to ensuring that "as a minimum" plans must focus on four things including "iii. improving the responsiveness of community health crisis response services to deliver the services within two hours of referral …" (p8)

However even as it was published it turns out that crisis-ridden Cambridgeshire & 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 (p13). It seems the fictional future technology of Star Trek is already a part of NHS England's plans.

For campaigners and health unions the Framework is a reminder of the scale of the challenge ahead to ensure services, and the funding for them are defended, and that the values and principles of the NHS are protected.

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 "My Choice" scheme which encouraged NHS patients to pay up front for access to dozens of treatments that have been branded "low value" and excluded from routine NHS provision by local CCGs.

According to HSJ reporter Lawrence Dunhill, Simon Stevens said the trust was 'misguided' in launching the self-pay scheme: Dunhill later clarified on Twitter that this comment referred to the marketing around the scheme - rather than the service itself.

However the inequality issues raised by the plan were immediately obvious – since many, especially older people who need these operations would not have the thousands of pounds required to pay for them, even at NHS prices: also obvious to many was the problem of opening up a whole area of the NHS in which charges become the norm.

Within 24 hours of the story being splashed over a Mirror front page, with mounting anger from local MPs and Shadow Health Secretary Jonathan Ashworth, trust bosses opted to pull the plan.

Soon afterwards in an unconnected but convenient move out of the limelight, Chief executive Mel Pickup, who had strongly endorsed the plan revealed she had accepted a new post as chief executive of Bradford Teaching Hospitals FT and "system leader" for the Bradford area.

But the underlying problem remains unresolved.

Seven CCGs in Merseyside and Warrington are still 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 are not routinely funded by the NHS unless patients reach a high threshhold of need.

"Choice"

So patients in the area who are in pain but do not meet this threshhold have a "choice" of going private … or going without.

The CCGs hide behind the pretext of helping to "reduce variation" of access to NHS services in different areas ("sometimes called 'postcode lottery' in the media") and "allow fair and equitable treatment for all local patients."

Many other CCGs have adopted similar lists, with varying numbers of treatments regarded as outside the NHS for elective care: some CCGs have lists of as many as 104 treatments, some have as few as the 17 imposed by NHS England.

So in reality the 'postcode lottery' is back, with a vengeance.

However the only real winners seem likely to be the private sector.

With a private medical insurance market that "is at best static", and private hospital chains facing a reduction in income in many areas for treating NHS-funded patients in otherwise empty beds:

"a shining light for the sector is strong demand for private healthcare from self-payors. Despite a 9% real increase in self-paying spending, LaingBuisson projected a real fall in overall acute care market value for 2017."

This private market can only benefit from the NHS increasing the numbers patients who cannot access treatment on the NHS, or are weary of long waits for operations, and are able to pay up front for private care. Many such patients will be elderly or already suffering pre-existing conditions that means they are not eligible for or cannot afford private insurance.

Momentum Halton and Weaver Vale

Protesters opposing the 'My Choice' scheme to charge patients for access to "low value" NHS operations

Seven CCGs in Merseyside and Warrington are still signed up to the same list of 71 treatments which are not routinely funded

Growth

According to private sector market analysts Laing and Buisson, "All the major UK hospital groups continue to report growth in self-pay patients, and as a result are marketing and developing their self-pay offering."

Income from self-paying patients has more than doubled from £493m in 2013 to £1.1 billion in 2017, according to a new "Self Pay UK market report" at the end of last year. Around 800,000 healthcare treatments each year are privately funded: in 2017 one in four of all private treatments were self-pay.

Prices for 'fixed price surgery' are now published on the websites of all major private providers. Laing & Buisson note that:

"it pays to 'shop around'. There are wide price variations for 'fixed price surgery' across the UK,"

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. And as CHPI research has pointed out the quality and safety of treatment in private hospitals give grounds for concern.

Whether its private hospital chains or Foundation Trusts with their hand out demanding cash for routine treatment, the expansion of "self-pay" represents an erosion of the NHS, and a drift back towards the grim days before 1948 when millions could not afford to seek treatment and were forced to suffer in silence.

The starting point for this is the long and growing lists of exclusions. Last week it took an intervention from the Department of Health and Social care to prevent a decision by Cambridgeshire and Peterborough CCG to impose an indefinite ban on NHS funding for IVF treatment, to save money towards its £75m deficit.

Ministers must now step in to force CCGs elsewhere to remove the barriers they have 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 he 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 new 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 stamping 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 punting in the opposite direction, asking for a review of the evidence, much of which is already sitting in our laps.

A study by the University of Cambridge in 2015 highlighted why a sugar tax could be so beneficial. Their researchers discovered that 8,000 cases of type 2 diabetes a year were linked to sugary drinks consumption. Since its introduction UK producers have reduced sugar content.

When a similar tax was introduced in Mexico sales of sugary soft drinks fell by 6% in first year. In France a sugar tax forced companies to reduce the sugar content by 30-40%.

In Berkeley, California a soda tax reduced consumption of sugary drinks by more than 50 percent.

A U turn on the sugar tax by a Boris Johnson led government would come as a bitter blow to all those who have fought hard for pressure on big business, against a powerful corporate lobby with strong links to the Tory Party.

In Berkeley, California a soda tax reduced consumption of sugary drinks by more than 50 percent.

New NHS shake-up?

This is not the first hint that a Johnson led government would take a different approach on health. At a recent hustings event he suggested that the NHS needed more re-organisation, saying it was "not getting the kind of support and indeed the kind of changes and management that it needs"

Details of how this would be done were scant, instead he reassured the audience of Tories that he would get together with Simon Stevens, the CEO of NHS England - an old pal from Oxford days, who helped him get elected to the Presidency of the union, to "sort things out". Over toasted crumpets no doubt.

More money for the NHS?

We learned recently that Johnson will not be prosecuted over his Brexit campaign claim that the UK sends £350 million to the EU every week, after the case – brought by campaigner Marcus Ball was thrown out by High Court judges. However, a quarter of people believed his promise that the NHS would benefit.

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 plead for more funds for the NHS ever since.

As foreign secretary, he marched into a cabinet meeting to demand £100bn for the NHS. A stunt trailed in the morning press, 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 apprentice 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 through 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.

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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 loyalties 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 privatise the 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 Bannon, calling it a "lefty delusion whose spores continue to breed in the Twittersphere".

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

How the NHS or any other domestic policy might be influenced by these far right associations is open to question, but the fact is Johnson is willing to go there, and contradicts his supporters claims that he is a "harmless" centrist Tory.

"The NHS is about as safe with them as a pet hamster would be with a hungry python," Major said

Full of contradictions

Boris Johnson can go misty eyed about the power of the NHS to care.

He described an emotional visit to an NHS unit where he met a young girl receiving treatment for her neurological condition, Johnson declared

"if she had been born in virtually any other country in the world, and if she had been born in any other epoch of British history, then she would have had zero chance of receiving that care."

There are signs too that he might clash with Matt Hancock, whose verve to see more virtual care in the NHS using apps, i-phones and skype to relieve the pressure on services seems at odds with most Johnson's recent comments.

"There is no robot that can provide that therapy. There is no app that can substitute for the patience and understanding of that young medic.

"You need a living human being to do that job, with a salary decent enough to allow him or her to live within reasonable distance of a hospital in London."

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 their close links to Tory minsters 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 and engaged public. As a populist, Boris will listen to the people - at least some of the time: and the people still want a publicly owned, well-funded NHS.

Bed shortage forces NHS to look to private sector

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 such private sector involvement is becoming more permanent.

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

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

Hospital trusts have 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.

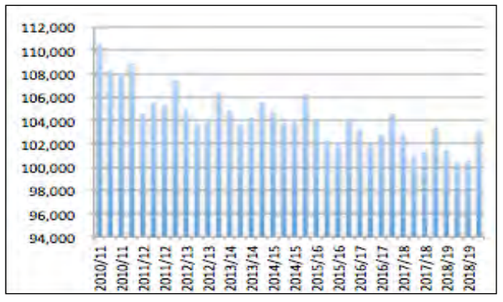
National bed shortage

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 an 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 20.1% of knee and 13.7% of hip replacements were carried out in the private sector, but this had risen to 29.4% and 19.7% by 2016/17.



Time series for general and acute beds - 2010/11 to 2018/19 - Source: NHS Digital

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

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 use 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 was 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 2019, 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 120-150 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 58% compared to March 2018.

Recognition from the top

Finally, in June 2019, Simon Stevens acknowledged at the NHS Confederation's conference in Manchester that the numbers of acute beds will have to increase over the next five years. Something that many people in the NHS have been saying for some time. Back in March 2018, NHS Providers chief executive Chris Hopson told HSJ it was estimated the beds shortage could be as high as 15,000 beds, 12% of the system's total bed base. Since this time, bed numbers have continued to fall.

Now a rise in bed capacity has received a seal of approval from the top, where will these beds come from? Will NHS trusts have the money and staff to open new beds or are the trusts going to be encouraged to seek additional capacity in the private sector?

Block booking

Will we see more block-booking of bed capacity in the private sector, as in Surrey, or the type of arrangement with Care UK in Plymouth?

In many cases the physical beds are there, just staff and/or money is needed to open them - the Guardian reported back in April 2018 that trusts had reported 82 "ghost wards" containing 1,429 empty beds that had been closed due to lack of staff and/or lack of money.

Of course, the private sector will be very keen on plans to increase bed capacity; the UK private sector is heavily reliant on the NHS and will have suffered a reduction in revenue due to the ban on elective surgery in the winter of 2017/18.

According to NHS Partners network, which represents non-NHS health organisations 515,000 non-urgent operations and surgical procedures were carried out by private clinicians for the NHS in 2017, about 6% of the total and the number will have risen over the last year.

Spire is one of the major private providers and NHS work contributed 29.2% of its total revenue at £272.2 million. According to its strategy outlined in its most recent annual report, "NHS waiting lists are getting longer and Spire Healthcare is part of the solution."

Imran's Photography / Shutterstock.com

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 other vital challenges, performance against key standards continue 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 and beds – 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 6.1 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 in 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 4 hours 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 99.6% 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 over 108,000.]

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 the poorest performance 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."

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

What the (research) papers say

JOHN LISTER looks at three recent academic papers with relevance to NHS campaigners

With a current health secretary so openly enthusiastic 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.

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 Babylon deleted any reference 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 debunked by a number of experts.

Now a new study by a team of German academics of research papers on the existence, use and benefits of digital technology in relation to nursing care has responded to the "lack of good empirical overviews of existing technologies".

They have found few papers based on efficiency studies, and many studies based on "a low level of evidence". The authors point out prior to their study:

"To the best of our knowledge, there is no review article that outlines the broad range of technologies developed to support formal and informal care, and no research findings are available that outline the existing evidence with respect to acceptance, effectiveness and efficiency for this broad field of technologies."

The team conducted a review of research papers in German or English produced over a 7-year period up to March 2018. Their extensive online search led to analysing 715 full text articles from 69 countries.

The findings are interesting, but not entirely surprising given the current poor level of critical reporting and discussion of new technology.

Little evidence on cost effectiveness

Very few of the studies focused at all on costs of technologies, and very few included full economic evaluations: most studies categorized as "efficiency-studies" offered only simple cost analyses. Indeed while 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-utility analysis.

There was also little focus in the research on digital support for informal carers: just 8% of papers considered this, while a vanishingly small number (less than 1%) saw children in need of care as a target group for digital solutions. Most of the studies were of technology for patients in need of care, or formal care givers.

The authors note that they found:

"large number of effectiveness studies with a focus on ICT, robots and sensors, and a large number of acceptance studies focusing on ICT, robots and EHR/EMR [electronic records].

"However, a large proportion of these studies has 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."

A large proportion of studies has a low level of evidence …. Efficiency studies are very rare in general.

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 surgical 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 treatments from 2012, and soon afterwards extended to some surgical patients, were large:

"The penalties were substantial in size: up to 3 percent of Medicare's base diagnosis-related group payments for each diagnosis in question, which is a ten- to fifteenfold larger incentive than pay-for-performance initiatives to reduce mortality.

"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 had a "great impact" on readmission reduction 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.

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 readmission reductions may be approaching 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 readmission "may have actually ***increased mortality*** for certain conditions, as some patients who should have been readmitted were instead discharged from the emergency department and died at home."

Hospitals that received penalties tend to serve more minority and low-income patients

There are also equality issues arising from the penalties:

"For instance, it is widely accepted that hospitals that received penalties tend to serve more minority and low-income patients and that their readmissions may reflect a failure of the social safety net rather than of their medical care. Safety-net hospitals bear the brunt of readmission penalties, and disparities may be widening at these facilities as they struggle to execute their mission in the face of sizable penalties."

The report tacitly admits that a factor in reducing readmission is properly coordinated discharge and support outside hospital – a factor which is of course a recurrent issue for the NHS.

In fact the penalties may have played a relatively minor role: the paper argues that provision of such joined up services by accountable care organisations "could have contributed to the observed decrease in readmissions."

Nevertheless, the authors are reluctant to recommend any relaxation of the penalties in the US. They believe repealing the program "would remove the strong financial incentive to coordinate care at discharge and could bring readmissions back to pre-policy levels."

How useful are NHS business cases?

In our last issue Richard Bourne pointed to the weakness of many 'business cases' setting out proposed changes in the NHS, and challenged the frequency with which commissioners and providers resort to spurious claims of "commercial confidentiality" to avoid disclosing the extent of this weakness.

Now a new research paper has for the first time attempted to develop "quality indicators" for healthcare business cases. It has many weaknesses, not least in accepting without question the claims that an undisclosed number of the business cases they examine were of a "confidential and sensitive nature," and therefore offering no specific critiques of identifiable business cases.

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, no doubt partly because of the researchers' limited and rather naïve approach, none of the questions they ask of business cases includes any critical appraisal of the honesty 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 management in the way a drunk uses a lamp-post: more for support than illumination.

Indeed many business cases are little more than cynical PR spin to sell a proposed change rather than a serious and critical exposition of the facts.

The researchers' lop-sided 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 limited critique offered by this paper is definitely better than no critique at all, the authors have bought so heavily into their 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 political parties.

These criticisms tend to focus on the merits of the changes being proposed, the 'evidence' produced, the practicality in terms of funding and staffing, the viability of the plans, and the needs and views of the communities affected.

The authors, from Bristol and Birmingham universities, do howeve recognise that: "a 'poor' business case may lack persuasion or, in more serious cases, misinform decision-makers about the relative strengths and weaknesses of available options."

They correctly make the point that bigger does not mean better: "Longer business cases were not necessarily any better at providing full coverage of the quality indicators, indicating that length alone does not necessarily guarantee quality."

They also note that "only one business case explicitly linked its proposal to a set of local needs."

However they go on without any sense of irony to discuss the application of the 'SMART' approach (specific, measurable, achievable, realistic and timely) despite having found that fewer than half of the NHS business cases analysed (7/15) even included explicitly labelled aims or objectives.

To progress beyond this limited exercise the authors would do well to break away from their debilitating ties to the CCG and begin talking to campaigners who have made detailed and successful challenges to business cases – in Shropshire, Huddersfield, West London, South East London and elsewhere – and to trade unions who even now are challenging business plans that seek to justify hiving off staff into "wholly owned companies".

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

THE lowdown

Health news, analysis and campaigns.
NUMBER 7,
July 20 2019

Informing, alerting and empowering NHS staff and campaigners

Both main parties call to bring NHS catering back in-house

The listeria sandwich scandal prompted even Health Secretary Matt Hancock to call publicly for NHS managers to end their dependence on external private suppliers and bring cooking back in house, with hospitals once again employing their own chefs and relying on quality local food.

That is the way it used to be before Margaret Thatcher's government artificially separated "hotel services" from the rest of the hospital and subjected cleaning, catering and laundry services in particular to competitive tendering.

Hancock, apparently oblivious to his own party's role in undermining standards of hospital food, called for a "root and branch review," noting that "dozens of hospital trusts" had improved food quality by bringing catering back in house.

Jon Ashworth

Catering was inhouse before Margaret Thatcher's government artificially separated out "hotel services"

Hancock also appeared blissfully unaware his shadow opposite number, Jonathan Ashworth, had called for precisely these changes, along with measures to enforce higher food standards, more than a year earlier. He said:

"Unlike schools and prisons there are no mandatory minimum requirements for hospital meals, so the next Labour government will substantially increase investment in our NHS to improve patient care including providing the nutritious meals patients deserve."

■ See pages 8-9

Image: Andy Stenning/Daily Mirror

Bradford staff go for second week of strikes

UNISON members at Bradford Hospital whose lively week-long strike has failed to secure any retreat from management could be set for further action.

The union if fighting to keep support staff 100% NHS, and against Trust plans to set up a tax-dodging "Wholly owned company,"

A letter from the branch quoted in the local Telegraph and Argus states: "Following a week of solid industrial action by estates and facility staff, the Trust has refused to cease or even postpone its plans to transfer staff into the private company Bradford facility services.

"The Trust stated in the meeting that they wished to look into ways of giving more assurance around terms and conditions but accepted that as yet they could not make guarantees that would legally prevent future changes to terms by lawfully terminating contracts and offering inferior ones.

"Unison informed the Trust that it will now seek to take more sustained action in view of the Trust's response.

"We are therefore in the process of issuing a new industrial action notice, with aim of taking a continuing and indefinite programme of action subject to regular democratic members meetings to ensure there is a broad consensus.

"In the meantime we are in the process of taking steps to ensure the strike is financially supported across the union and labour movement as a whole."

Please give solidarity, and sign the petition: https://t.co/36IOCztADi

IN THIS ISSUE

Cambridge and Peterborough cuts home in on community services

This week Cambridgeshire and Peterborough CCG announced a first round of £2.8 million in spending cuts affecting a range of services including brain injury rehabilitation, ophthalmology service, and dermatology with a further £1.3m expected later in the year.

It looks like community services will take the largest hit, with an urgent response team (JET) that supports over-65s with long-term conditions in their homes under threat.

The JET team responds within 2 to 4 hours when patients feel unwell, carrying out an initial assessment and developing care plans with patients and their GPs to prevent hospital admission.

An NHS Improvement report on JET revealed that the team had an admission avoidance rate of over 70%, preventing around 7000 hospital admissions a year,

Despite its plaudits Jet is part of cuts plan being drawn up by Cambridgeshire and Peterborough CCG in an attempt to turnaround a £75 million deficit and overspending of around £1 million a week.

The scope of the CCG's planned cuts are likely to hit community non-emergency transport services, stroke patients and carers support charities, plus further restrictions on IVF treatment according to Board papers.

Last month, health minister Jackie-Doyle Price wrote to Cambridgeshire and Peterborough CCG, amongst others, condemning their rationing of IVF treatment. Since 2017, the CCG has suspended its IVF treatment programme contributing to the emerging postcode lottery for this service.

The CCG blames a lack of funding and disparities in the way government money is shared out, pointing out that it is the third lowest funded CCG in the country, with others receiving up to £350 per person more.

The CCGs the third lowest funded CCG in the country, with others receiving up to £350 per person more.

Jo Rust, regional organiser for UNISON, who took part in a protest as the CCG considered its plan, told the ***Peterborough Telegraph*** that she had some sympathy for the CCG's argument that they are underfunded, but added that the cuts were worse than they looked, and warned that some were going "beneath the radar" as they were not affecting hospital trusts directly.

● We will follow this story and similar cuts elsewhere in future issues of ***The Lowdown*** after the summer break.

Privatising public involvement

While Matt Hancock claims there will be no privatisation on his watch, his own Department for Health and Social Care is proceeding to further privatise even the process of patient and public involvement.

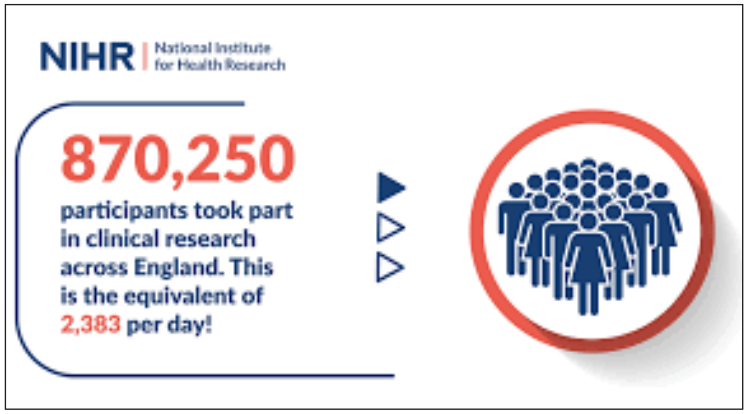
The National Institute for Health Research (NIHR) is merging its INVOLVE function with its Dissemination Centre, and the contract to run the new centre from April 2020 was put out to tender by the DHSC, and won by LGC, a once publicly owned body that was privatised by John Major's government and has since been bought up by a US-based private equity giant KKR.

LGC is still keen to trace its origins back to 1842 when the Laboratory of the Board of Excise was founded in the City of London to regulate the adulteration of tobacco which was prohibited under the Pure Tobacco Act.

Industrial vision

This developed into a wider-ranging Laboratory of the Government Chemist, but was eventually flogged off in 1996 and renamed LGC, and was subsequently bought up by KKR, which describes itself as a global investment firm 'with an industrial vision'.

The Dissemination Centre had already been partially privatised, run in partnership between Southampton University's Wessex Institute and another private outfit, Bazian, which was taken over in 2013 by the Economist Intelligence Unit.



The INVOLVE function was set up to promote patient and public involvement (PPI) in NIHR-funded research, and has also been hosted by the Wessex Institute, but until now without a private partner.

While the decision now to hand both operations over to LGC on a five year contract offers the possibility of some juicy data for LGC and its private equity owners, it does raise the question of what possible benefit the DHSC might argue this latest privatisation could deliver to the public.

The first six issues: with pilot issues we have now been publishing for 6 months

Successful lift off for the Lowdown – help us take the next step

Thank you for your interest and support for the Lowdown. In just a few months you have helped us create a regular publication that provides analysis and news about what's really happening in the NHS and crucially, connects our readers with campaign actions to help change the issues that we all care about.

We now need your support to sponsor our journalists and researchers to step up this important work. Please help us with a donation today.

Through the Lowdown, a growing community of NHS supporters is being kept up to date and joining in with local and national campaigning. Already information shared by our readers has helped us to investigate some shocking issues.

Plans to privatise a world renowned NHS PET-CT scanner service in Oxford. Ministers say they are turning away from outsourcing, but our research keeps finding evidence to contradict this and we will not let this issue go.

Debt-ridden NHS trusts are cutting their NHS treatments and urging patients to go private in NHS pay beds. Our team is collecting evidence from across the country to fuel campaigns to keep our NHS comprehensive.

Some mental health services are at breaking point from understaffing and cuts. Tragically patients are dying because care does not reach them soon enough. Children are waiting too long and often travelling hundreds of miles for care. We have been looking at the reasons why and how we can change it.

These issues are pressing, causing huge and unnecessary suffering. The NHS is too often struggling to provide the standards of care that it wants to. However, we believe this can change as the evidence points to the failings of key policies on health planning, staffing and capital improvement and not the core ideas behind the NHS.

We need your support to help us to investigate and publicise these crucial issues. If you can, please make a donation today.

By sponsoring our researchers and journalists you will help us to alert NHS supporters across the country, challenge our politicians and put the focus on the solutions, supporting NHS staff in improving the service.

It is often hard for NHS supporters, trade unionists and staff members to keep pace with the issues and yet the NHS relies on our support. The Lowdown aims to make it easier, summarising the news, providing regular explainers and analysis. This is a new service that we want to keep building.

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

If you can, support us with a donation, but you can also help by sharing our content and by sending us information about what's happening in your local NHS.

We are off now for a short break in August and to spend some time recruiting new contributors and getting some feedback to improve the Lowdown. We'll be back at the beginning of September. In the meantime, thank you for all your support.

Best wishes
Paul, John, Sylvia, Molly and all our Lowdown contributors

We need your support to help us to investigate and publicise these crucial issues.

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

CCG springs a leak in choppy North West London waters

John Lister

Signs of dislocation and chaos continue in North West London after the flagship "Shaping a Healthier Future" project – which had threatened to close A&E and acute services at Ealing and Charing Cross Hospitals – was belatedly scrapped by Matt Hancock in April.

The Clinical Commissioning Groups remain mired in debt, entering 2019/20 with an underlying deficit of £99.6m, while many of the main NHS and foundation trusts are also deep in the red.

A leaked "crib sheet" drawn up to supply senior managers with prepared answers to difficult questions about the collapse of the plan, which wasted over £230m, has revealed that even NW London communications supremo Rory Hegarty has been unable to suggest convincing replies to some questions, such as **"How will you change the way you make decisions in future to ensure millions more pounds of taxpayers money isn't wasted?"**

The crib sheet is consistent in offering no apology for the fiasco, and in giving a flat "No" to the question on whether anyone responsible will resign.

Citizens Panel

Instead the management team that so conspicuously failed to consult or engage with affected communities or boroughs in during most of the 7 wasted years of the project have been trying this year to reinvent themselves as advocates of a new "Citizens' Panel" to "to support, comment on and develop our thinking on a range of healthcare issues".

When this idea was first floated at the end of February 2019 it was proposed as an enormous 4,000-strong body – 80 times larger than the NHS Assembly established in the spring.

Where the Panel might meet or how it might function was not explained.

However it seems that senior managers have already got cold feet over this idea. By May 2019, plans for a single Clinical Commissioning Group to cover the 2.2 million population of NW London across 8 boroughs claimed less ambitiously: "we are putting in place a 3,000-strong Citizens' Panel across NW London – a demographically representative group from which we will regularly seek feedback."

Campaigners point out that if the current rate of shrinkage (25% in 4 months) continues, mathematically there will be no membership left for the 'panel' by February 2020. Perhaps this is why nobody has sent out any invitations for people to join it, and no dates or venues have been announced for meetings?

Far from pulling the team together, the awayday event seems to have underlined the divide between staff and senior managers

Away Day

Meanwhile efforts to engage with staff in the 8 CCGs which are set to be streamlined down to just one have proved less than a roaring success.

Details have been leaked of an 'away day' which over 500 staff were required to attend, where management – (perhaps unwisely) arranged for staff to be able to text or email live feedback and questions on their presentations.

Although only the feedback has been leaked, it appears few if any of the questions raised in this way were answered by the panel on the platform.

Indeed far from pulling the team together, the event seems to have underlined the divide between staff and senior management, headed up by NW London 'Accountable Officer' Mark Easton, who appears to have adopted a prudently low profile as the event went belly-up, prompting repeated questions of why he was not answering points raised.

Management read out tedious and previously scripted answers to the questions they imagined staff might ask, but failed to answer the most commonly asked questions – on how many jobs would be lost in the process of merging the CCGs, and what terms would be offered to staff.

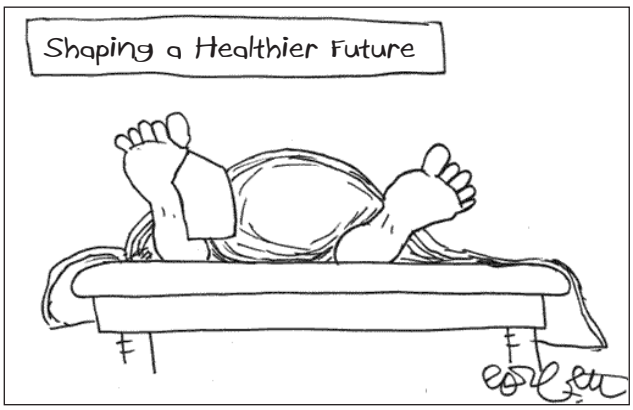
Nor did they respond to any of the questions on the collapse of the SaHF project and the money wasted on it.

Frustration

Many of the questions and comments highlighted staff frustration and anger at inflated salaries paid to management consultants and "interim" staff, some of whom had stayed on for months or years, as well as fears that job losses will be largely among lower ranks of staff with those at the top clinging on, anger over bullying, and a general sense of lack of management competence: "Why are there so many Project Managers paid ridiculous amounts of money who don't deliver their projects successfully but then get assigned to another project?"

The tenor of the feedback to this morale-raising exercise suggests a worrying level of cynicism and disaffection among the CCG staff who are supposed to plan and commission health care in NW London.

It seems that rather than draw up plans for an imaginary Citizens Panel of thousands, and creating platforms for them to rehearse their set speeches, NHS bosses would do better to start by listening to their own staff and responding to the questions they are actually asking.



Early closure for stroke unit – or is it just as planned?

John Lister

The premature closure of stroke services at Tunbridge Wells in September rather than the scheduled date of next March was one of the most predictable outcomes of a massive reorganisation of services that has blighted four threatened stroke units in Kent.

In addition to Tunbridge Wells, stroke services are to be axed in Medway, QEQM Hospital in Margate; and the "temporary" closure of stroke care at Kent & Canterbury Hospital is to be made permanent – all to make way for just three new specialist "Hyper Acute Stroke Units" in Maidstone, Dartford and Ashford, which are not set to come on stream until March.

The Maidstone and Tunbridge Wells trust has now admitted to Kent County Council's scrutiny committee that from next month the thrombolysis service at Tunbridge Wells can only be staffed 9-5 Monday to Friday and on some weekends.

The Kent committee has repeatedly failed to take any action to challenge the plan, despite the fact that the three remaining HASUs to cover the whole of Kent will mean marathon journeys from many areas, with the potential for heavy pressure on the reduced number of beds.

Medway council has highlighted warnings from the Clinical Senate on the likely pressures on the centralised stroke services from the increasing proportion of elderly people in Kent and Medway, together with the increase in the overall population.

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

It was always going to be hard to recruit staff to a doomed unit. The Business Case itself pointed out 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".

Campaigners will feel quite reasonably that this "risk" was so foreseeable it is effectively part of the plan, which is now closing units before any of the proposed specialist units are complete. This looks like orchestrated decline rather than a plan.

Medway Council has referred the plans to the health and social care secretary and the local Save Our NHS in Kent (SONIK) campaign is among those planning a judicial review.

Towards a two-tier NHS

The Health Service Journal has revealed that some NHS hospital trusts are allowing patients to pay privately to have procedures which are banned or tightly restricted as a result of NHS England guidance last year.

A "relatively narrow" initial list of 17 treatments to which access would be restricted or in four cases virtually banned was published last July: a few of the treatments were declared to be ineffective, although most of them were still to be available – as long as the CCG gave prior approval.

The list became a rigid rule on April 1, but NHSE made clear from the start their plan was to "rapidly expand" beyond the initial list, to a "much wider, ongoing programme" of restricting access to NHS-funded treatment.

Many CCGs have moved rapidly – apparently with the consent of NHS England, which has not intervened – to draw up increasingly lengthy lists of dozens of excluded treatments, leaving patients a choice of going private or going without.

This resulted in the recent scandal when Warrington and Halton hospitals trust attempted to cash in on the long local list of exclusions, which includes hip and knee replacement and cataract operations, and offer them privately to patients able to pay thousands of pounds, creating a 2-tier NHS.

The trust retreated rapidly when its plan was exposed by the Daily Mirror.

The HSJ points out that many trusts have looked to expand private units to generate income in recent years. Some are seeking to tap into the fastest-growing sector of private medicine, the "self-pay" treatment of patients who do not have private health insurance.

According to market analysts Laing & Buisson self pay surgery and treatment accounted for £1.1 billion of revenue for independent hospitals and clinics in 2017, up 9% on the previous year, and more than double the reported £493 million revenue in 2013. The NHS, too, continues to be an important provider of self-pay treatment.

Laing & Buisson argue that key drivers for this market include "the cancellation of elective procedures owing to pressure created by non-elective admissions in the NHS … coupled with increasingly restrictive funding criteria for elective procedures on the NHS, especially in orthopaedics, ophthalmology, gastroenterology, gynaecology and urology."

Appeal to governors to stop PET privatisation

Amid fears that a contract is about to be signed behind closed doors, Oxfordshire Keep Our NHS Public has written to all 27 members of the Council of Governors of Oxford University Hospitals NHS Foundation Trust, calling on them to halt the privatisation of the PET-CT scanning service at the Churchill hospital in Oxford, and to back the referral of the matter by the county's Joint Health Overview and Scrutiny Committee to the Secretary of State for Health.

Their letter points out that the clinicians at the Churchill have grave concerns about the impact of the proposed privatisation on the quality of service for patients, but also notes that

"legal steps by the Trust to oppose the imposition of privatisation of the PET-CT scanning services were in place in July 2018" before "they were suddenly dropped following an intervention by the then chair of the NHS England, Lord Prior."

The letter also notes campaigners' concerns over the failure of OUH's chief executive Bruno Holthof to stand by the clinicians, who are refusing to join "partnership talks" as a result of their concerns over patient safety. And it adds:

"We understand that you may not have been fully informed of these matters in a timely way in the past."

Chronic failure of Norfolk & Suffolk trust board, CQ

Mental health trust is still unsafe

John Lister

The Norfolk and Suffolk Foundation Trust (NSFT) is England's worst performing mental health trust, and remains bogged down in 'special measures,' although these measures have done nothing to address the deeply flawed management regime, or prevent it receiving a third 'inadequate' rating from the CQC last November, and again being branded as unsafe.

The chronic failure of the trust comes despite (or possibly as a result of) it having a massively inflated proportion of managers: and this is getting worse.

In 2017 the local ***Eastern Daily Press*** (EDP) revealed that while the number of doctors and qualified nurses at NSFT had fallen by more than twenty per cent over the last five years as a result of cutbacks, the number of managers had risen by more than fifty per cent.

Angry campaigners have pointed out "NSFT has 67 per cent more managers than the Norfolk and Norwich, a university teaching hospital with three times the turnover, nearly twice as many qualified nurses and more than five times as many doctors. …. NSFT employs 1.3 doctors for every manager, while the Norfolk and Norwich employs 12.25 doctors for every manager."

However repeated CQC reports since 2013 show clearly that this proliferation of managers are not delivering results that justify the resources they consume.

The BBC has reported that numbers of disruptive out of area placements of mental health patients for whom there are no local beds have trebled in the past 12 months, with some Norfolk and Suffolk NHS Foundation Trust patients are being cared for hundreds of miles away. The number of bed days for out-of-area placements in April 2019 was 1,911, three times the April 2018 total.

"The system is broken. We [the police] are filling the gap in mental health services that do not really exist."

Steve Adams Eastern Daily Press

Melt down

Campaigners argue that the beds crisis has been caused by a meltdown in community services, and the closure of more than 140 beds by the mental health as part of the disastrous 'radical restructure' in 2013 aimed at cutting spending by a massive 20%.

"Two of the three city adult community teams have been closed to routine work due to lack of staff.

"Nurses carrying caseloads of 60+ who routinely work until seven o'clock in the evening are being followed around by expensive management consultants to see how they spend their time."

An EDP report this month on their findings from a Freedom of Information request reveals Norfolk police are now dealing with an extra 10,000 mental health incidents each year compared with 2014, with over 6,000 a year coming through emergency 999 calls.

Andy Symonds, chairman of the Norfolk Police Federation, told the EDP: "The system is broken. We are filling the gap in mental health services that do not really exist."

Earlier this year an EDP Freedom of Information request revealed people in Norfolk had been detained in police stations for more than 40 hours awaiting assessment or transfer to hospital.

CQC reports

According to the most recent CQC reports, high staff turnover, vacancies, staff away on courses and sickness all contributed to an unmanageably high case load for staff at the Ipswich home treatment team, juggling the needs of 50 patients.

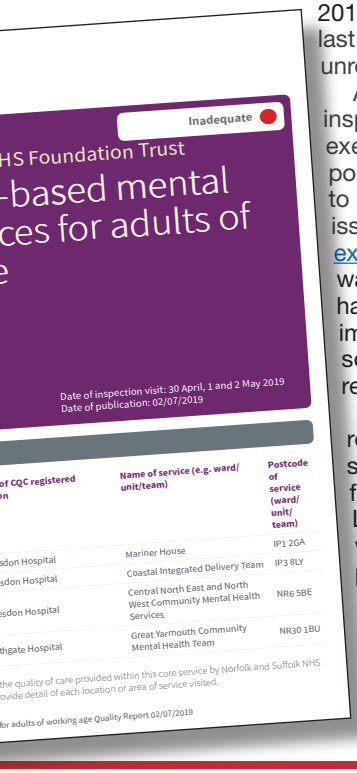
QC and CCGs

Not surprisingly this care was care that was "variable and at times poor" said the CQC after an unannounced inspection.

The inspectors were told that in Norwich the crisis and home treatment team was not consistent in providing safe care, and that staff failing to visit patients as planned was a "daily occurrence".

A separate unannounced inspection of the trust's community-based mental health services for adults also rated it inadequate.

The trust was rated inadequate in the summer of 2017, and an interim inspection last August raised significant unresolved concerns.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Date of inspection visit: 30 April, 1 and 2 May 2019
Date of publication: 02/07/2019
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the quality of care provided within this core service by Norfolk and Suffolk NHS
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or adults of working age Quality Report 02/07/2019

After each of these inspections the current chief executive has tried to find positives, while clearly failing to address the underlying issues. Last August, then chief executive Antek Lejk said it was "heartening" the report had acknowledged the trust's improvements, but insisted some issues "cannot be resolved overnight."

Six months later having repeatedly failed to resolve the same problems he departed for a senior post at the East London Foundation Trust, with a generous severance package.

Campaigners have been critical of what they see as ineffective CQC intervention over the five years of more since serious concerns were flagged up in 2014.

"We find it incredible that providing care to this number of people, with 24% fewer staff can be done in such a way that does not affect the quality or safety of patient care."

It's clear services have been struggling as a result of staff shortages and under-funding by CCGs, but things have been made much worse by consistently poor senior management which redesigned services in 2013 as a response to a 20% cut in its budget, cutting staff and frontline teams. In four of the following five years there were further cuts in funding.

Special measures

In 2017, having failed to address serious concerns raised by the CQC three years earlier, NSFT was placed again in special measures, after a previous spell from 2015-2016, with the CQC again calling for a host of improvements.

CQC's chief inspector of hospitals Ted Baker said:

"It is extremely disappointing that on our return to NSFT we found the board had failed to address a number of serious concerns. The trust leadership... must ensure it takes robust action to ensure improvements are made and we will continue to monitor the trust closely."

Six years ago officers of the UNISON branch covering the Trust wrote to the joint Health Oversight and Scrutiny Committee to express their concerns over the planned cutbacks and their impact.

They warned that

"Whether you euphemistically call it "Radical Pathway Redesign" or "Service Strategy" the reality is that this is a significant cut to local mental health services, and should be described as such. To not do so causes confusion and ambiguity in the minds of the public."

UNISON noted that the proposed reduction of 502 whole time equivalent staff represented a reduction in 24% of front line clinical staff, so that the same number of patients would be seen by this 24% reduced clinical workforce. They went on:

"We find it incredible that providing care to this number of people, with 24% fewer staff can be done in such a way that does not affect the quality or safety of patient care. There is no evidence that teams or clinicians currently have 24% spare capacity, or that clinicians' time and skills are underutilised."

Risk register

UNISON also warned that the risk register for the cuts was inadequate, and not sufficiently up to date, and suggested the HOSC request to see the risk register, and any plans in place to mitigate against gaps in service provision and risks. They endorsed the concerns raised by both the RCN and BMA that the proposed measures for monitoring the risk of these changes focuses too heavily on "safety" rather than "quality".

Nine months later, early in 2014 the Campaign to save Mental Health Services in Norfolk & Suffolk also issued a detailed call for the HOSC to press for a change of course, asking What has gone wrong with the radical redesign?

Sadly all this prescient good sense went unheeded by councillors, CCGs and a trust board seemingly intent upon multiplying highly-paid management jobs at the expense of front line care.

The latest failure is therefore a combined failure of trust board, along with a proven failure of CQC special measures to make NSFT services safe, along with the chronic failure of local commissioners to allocate adequate resources to mental health services, and of governments since 2010 to provide adequate funding for the NHS.

How much longer will the agony go on for mental health patients in Norfolk and Suffolk?

Hungry for action: the long fight to improve hospital food

John Lister

In recent years celebrity chef James Martin has led the most determined attempt to get hospitals sourcing, preparing and serving fresh, locally produced food for patients, and for staff.

Unlike many of the expensive gimmicks that had fruitlessly spent up to £50m under New Labour, including attempts by top chefs and by Lloyd Grossman to introduce unrealistic new menus from top down, Martin focused on the basics, reopening or making much better use of what kitchen facilities were available, and working with staff to find viable solutions.

However Martin also worked to debunk some of the false assumptions which made hospital trusts opt for buying in cook-chill food (and sandwiches) rather than preparing any food on site.

High quality, mass produced cook chill 'ready meals' are of course popular when sold by Marks and Spencer, Waitrose and by other supermarkets.

Low budget

However the restricted budget for NHS meals (with amounts spent on food varying between trusts from as little as £2.12 per patient per day to £10.50 in 2015) limited the quality of ingredients, and the way they were actually served to patients, often luke-warm after being wheeled around a large hospital for an hour in a heated trolley, meant that they tasted very different from the dishes management were able to sample straight from the producer's oven.

And while an individual cook chill meal may appear to be cheaper than a freshly cooked one, they don't come as individual meals, but as trays of up to eight, which can mean high levels of waste.

With growing awareness of the hazards of single-use plastic and focus on environmental sustainability the large volumes of plastic packaging and additional food miles from production centres are an unnecessary environmental cost. When the Royal Free hospital reverted to home produced food it ended the need for 50,000 disposable plastic containers.

Martin worked with hospital staff to produce three excellent series of 'Operation Food', proving that investment into kitchens and locally sourced food could enhance the food for patients and for staff – reduce wastage rates and even generate a modest surplus where there had previously been a cost.

But it was an uphill battle against management who had decided in advance that cook chill, or the replacement of hot meals with sandwiches was the only way to go.

It was also done without any support from government.

When Health Secretary Jeremy Hunt in 2014 refused in advance even to consider bringing in new legislation to enforce minimum food standards in hospitals regardless of the outcome of an inquiry, one government advisor resigned in protest and Martin responded "You should be ashamed." He denounced the persistent refusal of ministers to take the issue seriously. "I've tried five years to speak to someone in government and the response is they're 'too busy'."

"I've tried five years to speak to someone in government and the response is they're 'too busy'."

Shutterstock

The report of the Hospital Food Standards Panel included a cost benefit analysis of some of the changes proposed, and estimated savings would more than cover the limited additional costs to a very modest annual spend of just over £500m a year on hospital meals for patients.

However the Panel argued against legislation to enforce action, and claimed it would be enough to introduce five recommended standards as "legally binding standards in the NHS Standard Contract".

Alex Jackson of Sustain, who resigned from the inquiry panel on this issue, pointed out that while school meal standards are enforced by law, there is no such legal safeguard for hospital food, and warned that what the Panel was proposing was "tinkering with commissioning contracts and hoping for the best".

He was right. In 2017 an article in Health Business noted that "negative discourse around hospital food dominates now, more than ever." It pointed to a review of progress two years after the HFSP's report which found widespread breaches of what were meant to be mandatory standards:

"For example, 48 per cent of hospitals were found to be non-compliant with the Government Buying Standards, whilst only 55 per cent of hospitals follow the BDA's Nutrition and Hydration Digest."

The food standards introduced into the NHS Standard Contract were not comprehensive enough, and because no real regulatory programme had been introduced, the result had been slow adoption of the standards.

Wrong issues

Perhaps even more worrying, the Panel had focused on issues which were not central to patients' concerns. In particular there were "no stipulations in the Government Buying Standards regarding the quality of food procured and served. In fact, this is not touched upon in any of the five standards introduced."

As a result the Panel missed the crucial point: "Even if meals and ingredients are ethically sourced, kind to the environment and nutritious, if they are badly presented and bad tasting, patients will ultimately be dissatisfied."

Part of the problem was obvious from the start: the Panel's 2014 report avoided any reference to the very low average amount available for catering managers to spend per head on NHS food – a point repeatedly stressed by the Hospital Caterers Association, which pointed out that when James Martin's first BBC 'Operation Hospital Food'

series was broadcast:

"It clearly highlighted the lack of investment in hospital kitchens and the limited food costs that many caterers are working with. James Martin was quoted as saying that the daily NHS budget allocation per patient was £3.49 for all food and beverages but in fact many caterers are having to work with far less.

"For many Trust Boards, catering is viewed as a low priority and in this period of economic crisis, many are looking for more ways to make cost savings".

The HCA also followed up after the third series in 2014, arguing that:

"We are aware that we still need to address a range of quality issues and establish uniform standards across the country.

"The HCA is, therefore, calling for a minimum food spend per patient per day as part of a campaign for the introduction of mandatory national nutritional standards for hospital food.

"We also want to stop CIPs (Cost Improvement Programmes) being applied to catering as short term solutions versus more effective long term funding".

Five years later, with both main political parties apparently calling for catering to be brought back in-house, but with real terms hospital budgets only fractionally higher than they were in 2010, it remains to be seen if we are really much closer to the necessary investment in kitchen facilities and staff that could make this a reality.

■ A future article will look at the alternative examples of how catering is done in Wales.

Campaign to bring NHS catering back in house

The Good Food Chain, the company that appeared to be at the heart of the listeria-contaminated sandwich scandal that caused the death of patients, has gone into liquidation. But the story does not end here. They were only a symptom of the dangers currently inherent in NHS food provision, argues PETE GILLARD, in a comment piece published by Keep Our NHS Public.

The Good Food Chain had been found by the Food Standards Agency ***not*** to be the source of the listeria. It seems it originated with their supplier of cooked chicken, Northern Country Quality Foods. The Good Food Chain were given the all clear to resume production.

But they faced a problem. They had to reapply for NHS accreditation. Given most of their business was with the NHS, the 43 NHS Trusts they supplied with cold meals, sandwiches and salads, they chose not to wait around for that to happen.

The Good Food Chain was a small company. It only employed 125 people, similar in numbers to a large hospital kitchen. It had no particular skill in preparing food for sick patients.

Cutting costs, cutting corners

The process of outsourcing food production from hospitals has been ongoing since the 1980s. Most of the new-build PFI hospitals were only provided with kitchens suitable for reheating pre-prepared meals, not cooking from scratch.

The drive has been to cut costs. Staff in private food production firms are frequently paid only the minimum wage. They do not receive NHS pay and conditions.

They are not part of the NHS family and cannot be expected to have the same loyalty, and understanding, of the NHS that directly employed staff do.

At the same time as staff costs are being cut, so is the overall cost of patient meals. Lord Carter's review of NHS spending in 2016 specifically targeted food costs. The average cost of a patient meal then was £2.70. Carter asked why some trusts were spending 2.6 times more per meal than the least expensive ones. NHS Improvement is calling for further cuts this year.

That is why sandwiches and salads have become so popular with hospital administrators. There is no reheating needed and it takes less time and effort prior to being served on the wards.

The regulator, the Food Standards Agency, has made this easier. In 2016 it relaxed its guidance that vulnerable patients should only be given sandwiches with a doctor's approval. Now all that is expected is 'good practice controls' to manage risk. All the patients who died in this listeria outbreak were vulnerable. If the Food Standards Agency had not changed the rules, they might not have been given the contaminated sandwiches.

As Nigel Hawkes in the BMJ points out that: "If hospitals provided hot food, infection by listeria would be prevented."

A risk to health

The cost-drive shift to cold food increases the risk of these sort of outbreaks. It is not as though outsourcing has led to better quality of food.

Research by the Campaign for Better Hospital Food in 2015 found that 1 in every 4 hospital meals was thrown away uneaten by the patients to whom they had been served.

A survey by Unison earlier this year of NHS employees saw 53% of the respondents saying that they would not eat food prepared for patients.

Patient food now seems to be seen as primarily as a cost factor. It is usually listed under 'Estates' in lists of savings to be made. There must be a recognition that good nutritious, and attractive, food is a key part of the care that should be provided in our hospitals. Outsourced suppliers, sandwiches, and unappealing reheated meals do not meet the need.

Even NHS England have recognised that nutrition training is now ignored in medical schools. Nurse training similarly rarely has more than a single lecture on nutrition in their training. And the professionals, the dieticians, as allied health professionals, are frequently in job roles that are amongst the first to be cut back when cost savings are made.

Further action is needed

If we want to avoid more tragedies like this listeria outbreak, we must reverse the current approach to food provision for patients. Keep Our NHS Public calls for patient nutrition to be considered centrally as a health issue not a cost issue.

We call for the ending of outsourcing of catering and the reinstatement of hospital kitchens, staffed by NHS employees, that can provide the hot meals and specialised diets needed by patients.

We call for NHS England to make good on their suggestion of the need to improve nutrition training for doctors, but also to extend it to nurse training, and to current staff who have received inadequate initial training.

Why are NHS hospitals and GP surgeries crumbling?

By Sylvia Davidson

The NHS's infrastructure is crumbling and disintegrating - 50% of GP surgeries are not fit for their current purpose, according to the BMA, and recent data shows that £6 billion is needed to complete the backlog of maintenance needed in hospitals and clinics.

Media reports have shown hospitals suffering sewage and water leaks, broken scanners and lifts, and inadequate heating.

Back in 2017, the Naylor report estimated that £10 billion would be needed to make the NHS fit for purpose and deliver the plans that had been drawn up around England to improve the NHS. The plan was for the NHS to raise at least £6 billion of this itself from land and property sales.

So what has happened since the Naylor report - well judging by the current situation, very little of the estimated £10 billion has materialised and what money is available has, has been spent on patching up and making do, rather than modernisation and making the NHS fit for purpose.

So who is responsible for the NHS infrastructure - its buildings and equipment?

The vast majority of the NHS infrastructure, hospitals and clinics, is owned by NHS trusts. Another chunk (12%) is leased from NHS Property Services Limited, a company wholly owned by the Secretary of State for Health and Social Care.

In primary care, the majority of GP surgeries are either owned by GP partners, primary care companies or leased from private landlords.

The upkeep and modernisation of the vast majority of these properties, in particular hospitals, is the responsibility of the NHS trusts. This is covered by the capital budget element of the NHS budget.

The upkeep and modernisation of privately owned GP surgeries is the responsibility of the GP partners or the primary care company that runs the surgery, or the private landlord that owns the surgery, depending on the leasehold agreement. GPs can apply for grants from NHS England to modernise their premises, otherwise they have to take out loans.

What is meant by the capital budget?

There are two types of NHS spending: capital and resource. The NHS's capital budget is used to fund long-term investments, such as buildings, equipment and IT, plus some maintenance and research and development. The resource budget is for the day-to-day running of the NHS, for staff and clinical services.

In recent years only around 60% of the NHS capital budget reaches NHS trusts, with the rest allocated centrally to areas such as research and development and other capital initiatives.

For each financial year, the NHS trusts, submit their plans for capital spending to the Department of Health and Social Care (DHSC). The sum total of these plans should not exceed the allotted budget for capital spending in the coming year.

Is there a budget for primary care infrastructure modernisation?

In December 2014 the government announced that £250 million per year (over four years) will be available to be invested in modern premises and technology. This was known as the "Estates and Technology Transformation Fund".

Some additional money has been allocated since, including £1 billion in June 2015, and in April 2016, NHS England set out an additional investment of £2.4 billion a year by 2020/21 into general practice, although this was not specifically for infrastructure modernisation.

The BMA survey, however, shows that this has not had sufficient impact on the sector. It appears that much of this money was targeted at creating seven day access to GP surgeries and increasing the workforce, rather than modernisation of GP surgery buildings.

The increase in capital funding was a pittance compared with the £6 billion worth of backlog maintenance that needs to be carried out by NHS trusts

What has happened to capital spending in recent years?

According to the Health Foundation the capital budget for hospital infrastructure has fallen in real terms over the last eight years, with NHS trusts in England seeing a 21% reduction in capital funding.

In 2010/11, capital spending by the DHSC was £5.8 billion, but by 2017/18 this had fallen in real terms to £5.3 billion, a fall of 7%.

As a result, the capital budget in 2017/18 was 4.2% of total NHS spending, compared with 5% in 2010/11.

Although these are the capital budget figures, it does not represent what has been spent over the past eight years. The constraints on the resource budget for day-to-day running of NHS clinical services and trying to keep waiting lists down, has meant that hospital trusts have raided their capital budgets, transferring money to enable clinical work to continue. As a result, work has not been carried out to maintain hospitals or upgrade facilities.

The capital budget for 2018/19 was £5.9 billion, which increased the overall to 4.6% of total NHS spending. This rise was a pittance, however, compared with the £6 billion worth of backlog maintenance that needs to be carried out by NHS trusts, according to NHS digital figures for the year 2017/18.

This backlog figure of £6 billion is the highest on record and over half of the backlog represents a "high" or "significant" risk to safety.

The NHS definition of its high-risk repairs are those that "must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution".

What effect is the lack of capital spending having on the NHS?

There have been regular reports in the media of hospitals suffering flooding, IT crashes and sewage system failures. These media reports are just the tip of the iceberg, however, there are many other incidents that don't make it to the media. Any incident interrupts day-to-day working, makes it harder and more stressful for staff to do their jobs, can worry and upset patients, and altogether reduces the efficiency of the NHS.

The BBC series Hospital opened its last series in January 2019 with scenes of a flood in the A&E department of the Royal Liverpool Hospital. Staff spoke of this being a regular occurence and their concerns of electrical failures and its effect on patient care.

A freedom of information request to all hospital trusts in England by The Labour Party, the results of which were reported in July 2019, found that in 2018/19 at least 76 hospital trusts in England recorded incidents caused by "estates and infrastructure failures".

Replies were received from 170 hospital trusts cataloging a range of incidents. Many involved sewage, including sewage coming through the floor on the ultrasound corridor of one trust in Yorkshire and the Humber.

Other incidents included leaks of wastewater and water into hospital wards, sewage coming up through the bathroom drains, broken lifts, inadequate heating systems, water running down walls and broken scanners.

July 2019 saw fire chiefs threaten to close down parts of four hospitals as they were so rundown they had become a hazard to patients and staff. The hospital trusts must now make improvements or face legal action.

Collapsing infrastructure is not confined to hospital trusts. In February 2019 a survey by the BMA found that only half of GP practice buildings in England are fit for purpose.

July 2019 saw fire chiefs threaten to close down parts of four hospitals as they were so run down they had become a hazard to patients and staff.

The survey also found around eight in ten practices said their practices were not suitable for future needs or anticipated population growth.

GP practices who lease their premises from the government-owned NHS Property Services also face the additional problem of rising rents and incorrect service charges. In June 2019, the BMA wrote to NHSPS asking it to address "astronomical" service fees for GP practices or face legal action.

The BMA notes that over the last three years, GP practices leasing their surgeries have seen fees rise without agreement and they have been charged for services that they are not getting.

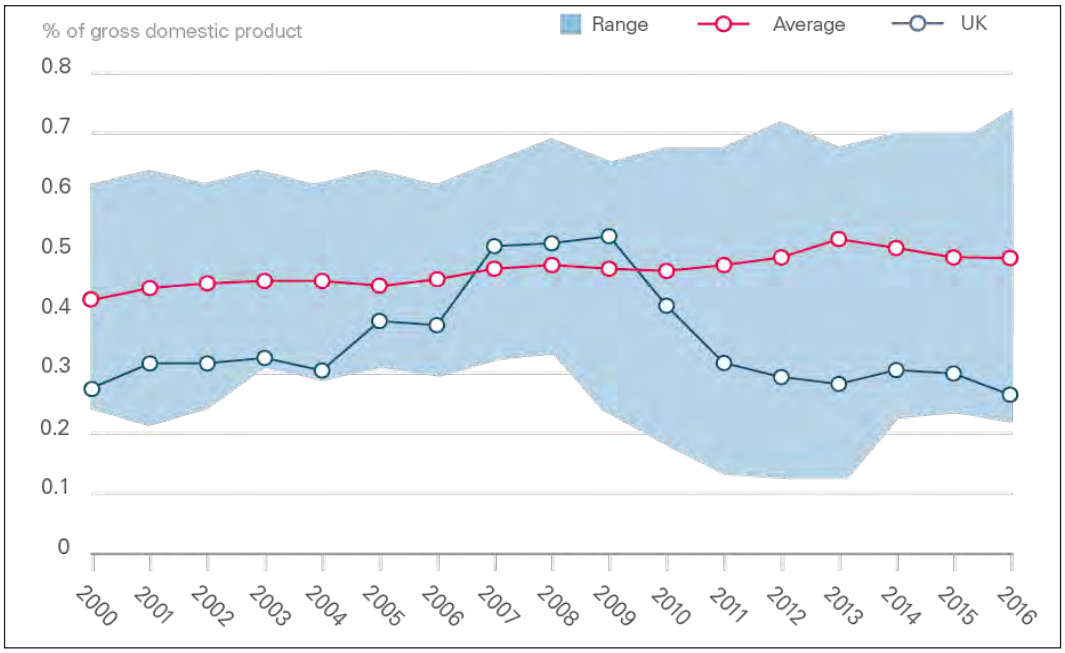
So is capital spending going to increase?

The capital budget for 2019/20 will be higher than in 2018/19, with some suggestions that it could be £6.7 billion. This budget has yet to be set by the treasury.

However, with a backlog of £6 billion in maintenance at the end of 2017/18, it is clear that the budget will not be sufficient. Furthermore, it is still possible for trusts to siphon off money from this budget to fund day-to-day running of the NHS.

At the start of the 2019/20 financial year, the hospital trusts submitted their plans for capital spending over the coming year to the DHSC. Due to the backlog in maintenance, the trusts naturally planned for a considerable amount of work. As a result, the hospital trusts collectively submitted spending plans that exceed the capital spending limit imposed by the treasury, according to the DHSC.

In a leaked letter seen by HSJ, the DHSC sent an instruction to all trusts, asking them to cut their planned 2019/20 spending to bring it back in line with the central spending limit.



Source: The Health Foundation, Organisation for Economic Co-operation and Development (OECD) data for OECD countries for which data for all years were available: Austria, Canada, Denmark, Finland, France, Greece, Ireland, Norway, Sweden, USA.

How do we compare to other countries?

Our spending on infrastructure does not compare favourably with other developed countries. According to the Health Foundation's report, Failing to Capitalise, to increase the NHS's capital funding in line with the OECD average, the budget would have to be £9.5 billion in 2019/20 - £3.5 billion on top of the current 2018/19 budget, and by 2023/24 an extra £4.1 billion would be needed.

Furthermore, this budget would all have to remain in the capital budget, with no transfers to day-to-day running of the NHS.

THE lowdown

Revelations fuel campaign against NHS charges and passport checks

Shocking revelations on the Victoria Derbyshire show have helped to drive a further strengthening of the campaign against legislation linked to Theresa May's "hostile environment" policy which requires NHS trusts to impose charges on patients without British passports, or who cannot prove they are normally resident in the UK.

Dr Joe Rylands told the BBC that he knew of a family who were denied access to the body of their baby because they were unable to pay the £10,000 bill. The family had been on holiday when the woman started bleeding severely and needed an emergency caesarean section. Sadly the baby died shortly after delivery.

The show also interviewed an Overseas Visitor Manager – the person who finds and charges patients – who revealed how they would simply scan hospital lists and pick out people with "foreign sounding names".

This bears out the suspicions of campaigners, who point out that a substantial minority of patients are being singled out for checks, apparently on arbitrary racial lines.

Earlier this year a Freedom of Information request by the Save Lewisham Hospital Campaign revealed that 18% of 9,000 women who gave birth in 2017/18 in the two hospitals in Lewisham and Greenwich were challenged to prove their entitlement to NHS treatment, and around a third of these, 541 women were charged.

Now the Royal College of Midwives has toughened its stance to demand the charges be suspended until it can be proved they are not harming women. The RCM also call for maternity care to be exempt from charges, whic "could put off women who need care but are frightened that they may not be able to pay in the longer term. This is potentially dangerous for the woman and her developing baby."

Protests have been held at hospitals in Bristol (above) Liverpool and London

The charges have also been opposed by the British Medical Association (BMA) and the Academy of Medical Royal Colleges.

The campaign against them is led by Docs not Cops, Medact and Patients not Passports, who are urging people to write to demand the Department of Health and Social Care commit to maintaining a truly universal NHS, available to all that need it, and specifically to stop charging for NHS care and repeal the 2015 and 2017 NHS Charging Regulations.

A Department of Health spokesman seeking to justify the charges claimed that since 2015, charges for people who are not UK residents had secured "an extra £1.3bn for front-line NHS services."

However this figure is deceptive. An investigation by FactCheck in 2017 pointed out that the initial target of raising £500m a year from charges did not just include the new upfront charges:

"Instead, it is the total annual amount that the government wants to recoup from treating overseas visitors by 2017/18. Upfront fees are only a very small part of this."

Fact Check found that most of the £500m was expected to come from other types of charges, such as pre-paid visa surcharges, which were introduced in 2015, and which are paid mainly by students and longer-term migrants from outside the European Economic Area.

The NHS had already become far better at identifying these debts before upfront fees were introduced and collected £358m in 2016/17 – which seems to correspond with the claimed £1.3 billion raised over 4 years.

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

THE lowdown

Health news, analysis and campaigns.
NUMBER 8, August 31 2019

Informing, alerting and empowering NHS staff and campaigners

Merger plans are seeking to flout the law

Campaigners call NHS England's bluff on CCG mergers

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Across England there are plans to merge Clinical Commissioning Groups: according to the HSJ, 86 of the remaining 191 CCGs are planning to merge into much larger bodies covering up to 2 million at a time. This threatens to marginalise any local voice or accountability for patients and the public in dozens of areas.

In South East London the six CCGs are to be merged into one covering a population of 1.8 million people; in North West London eight CCGs have been planning to form a single, monster CCG which campaigners fear will be largely impervious to the needs or demands of 2.2 million people.

Many if not most of these mergers are going ahead without any public consultation. This is important because the scrapping of locally based CCGs would remove the already limited level of public democratic accountability. At present each CCG must meet in public, publish board papers, and consult on changes.

211 CCGs were set up in 2012, when the Health and Social Care Act amended the previous 2006 Act. Their task was said to be to commission the majority of health services for their population.

"Local" and accountable

Indeed CCGs were initially portrayed as local organisations: when they were first proposed in the ridiculously-named Liberating the NHS White Paper in 2010 the promises of local democracy were extravagant:

"The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level".

Subsequent guidance insisted that, contrary to current plans: "CCGs' vision and plans will be accessible to a diverse range of communities and groups … to enable CCGs to be leaders in sustainable healthcare and accountable to the population they serve. … CCGs will have a strong sense of place."

Of course the real reason for establishing CCGs was to promote the marketisation of the NHS by compelling CCGs to put services out to competitive tender: the promise of a greater local say over services was only window dressing to make CCGs palatable. In practice most CCGs have failed to live up to this expectation and have generally ignored the views of the public and failed to engage front line clinicians.

Local GPs had raised concerns about the plans

But there have been some important exceptions, most notably Lewisham CCG which joined with the public and Lewisham Council in successfully opposing plans to close Lewisham Hospital.

Any such potential will be lost when the CCGs are merged into giant, remote organisations: that's why this merger process is being driven from the top.

Now Lewisham Hospital campaigners are demanding that there be full public consultation on CCG merger plans – and they believe they have the law on their side.

The campaigners have gone back to the amended NHS Act 2006 which (14G) stipulates that CCG mergers involve both the dissolution of the pre-existing CCGs and the formation of a new CCG.

And they have found that according to the Regulations governing the implementation of the Act, dissolution of a CCG requires the CCG to seek the views of all the people in the CCG area. Indeed, whether the CCGs are being dissolved, varying their constitution or changing their areas and memberships, the Board authorising the change is supposed to assess:

"The extent to which the CCG has sought the views of individuals to whom any relevant health services are being or may be provided, what those views are, and how the CCG has taken them into account" (Schedules 2 and 3).

This means a public consultation is required and not the partial "engagement with stakeholders" that is currently taking place.

More of the legal details are available to assist campaigners, councils and scrutiny committees wanting to defend the last vestiges of local accountability in the NHS: see the information posted by the Save Lewisham Hospital Campaign.

IN THIS ISSUE

What does the US want on the table?

John Lister

Since Donald Trump first let slip that he wanted the NHS to be "on the table" in any trade deal with the US after Brexit, debate has continued on exactly what might up for grabs as a result.

The belated and repeated statements from PM Johnson and Trade Secretary Liz Truss that there was no question of putting the NHS "up for sale" lack conviction, not least because flogging off the whole NHS was always the least likely outcome: there are so many parts of the NHS that US corporations seeking profits would find unattractive.

It's also the case that especially since the Health & Social Care Act of 2012, US corporations have been free to bid for contracts to run NHS clinical and support services. So far not many of them have done so: the greatest inroads have been im mental health.

But as a recent article by Kate Ling of the NHS Confederation points out, even operating on World Trade Organisation (WTO) terms after leaving the EU without a deal won't force commissioners to invite bids from overseas companies to provide NHS services:

"It will be for the Government of the day to choose, when negotiating, what kind of services foreign providers can bid to supply."

This will not fill many campaigners with confidence. Of course the driving force so far in privatisation of NHS services has been the British government, whether that was New Labour from 2000, David Cameron supported by Lib Dems from 2010, or Tory governments since 2015.

However the US is most likely to focus not on taking over services but on other highly lucrative areas, notably the pricing of medicines – seeking to dilute or remove the agreement with the pharma industry under which the NHS caps its expenditure on branded medicines, paying far less than in the US.

The driving force so far in privatisation of NHS services has been the British government

The US pharma giants would also like to strengthen intellectual property rights for companies who hold patents and data about the drugs they market, which could delay patient access to cheaper generic drugs.

There is also the threat they might push for access to the British NHS's unique database of 55 million patient records, which have been estimated to be worth £5 billion per year to private companies. Consultancy.uk has highlighted a recent paper from professional services giant EY which claims that the NHS could tap into a vital source of funding by opening up its patient records to private entities.

The NHS Confed also says it is concerned to prevent any further inroads into the NHS. It urges government action (changes in the law) that would "Ideally, exclude publicly funded healthcare services completely from the scope of a future free trade agreement (FTA).

"Or, if they are within scope, explicitly exempt them from commitments that would, for example, oblige the NHS to allow the trading partner's companies to bid for NHS business…."

However the Confed says it is happy to allow commissioners to choose to put services out to tender.

In other words even if we can keep the Americans at bay, the real challenge in pressing to keep our NHS intact is to stop our own home grown CCGs and Trusts ***choosing*** to put more NHS services out to tender.

CCG mergers spreading like a rash over England

John Lister

The top-down drive to force through CCG mergers, as discussed on our front page, is at its most frenetic in London, where 32 CCGs could be reduced to just five if current plans are rubber stamped by NHS England.

In North East London Hackney Healthwatch has raised the question of whether City & Hackney CCG's days are numbered, given the lack of any public discussion or consultation as plans progress to merge seven CCGs into one. City & Hackney CCG dodged a series of direct question on the plans for merger, and it's clear there are no plans for public consultation.

In North West London, as previously highlighted in The Lowdown back in June, the same eight CCGs that tried and failed to force through their half-baked Shaping a Healthier Future plan to axe hospitals and beds, are now seeking a merger to form a mega-CCG covering 2.2 million people.

They hope it would clear the decks to push through controversial plans by closing down the individual CCGs, and thus making it easier to ignore community views and boroughs like Hammersmith and Fulham and Ealing that might speak up for the needs of local people.

In South East London, six CCGs could also be merged into one, again gagging the more responsive and progressive voice of Lewisham CCG by eliminating it from the scene. CCGs South West and North Central London are also set for merger, regardless of the opposition from local boroughs, which could only influence decisions if there were a formal consultation.

According to the HSJ a further 17 areas are planning to make applications for mergers – among them Kent and Medway, Durham and Teesside, Staffordshire and Stoke-on-Trent, and Herefordshire and Worcestershire.

September deadline

There is a September deadline for 2020 merger proposals, each of which will need approval from NHS England. It's claimed that mergers would offer cost-savings and the development of system working, but it's clear any such savings would come at a cost of reduced accountability and local engagement.

The *HSJ* notes that, as with efforts to create "integrated care systems" a potential obstacle to the merger process is the financial impact on areas whose CCG is in a relatively healthy position, as they merge with others deep in the red.

But top-down pressure for merger, combined with an apparent determination to push the process through behind the scenes to avoid public debate and disclosure, seem likely to be the most decisive factors – unless campaigners can manage to force CCGs and NHS England to comply with the regulations they are currently ignoring.

Top-level censorship on NHS Brexit problems

So-called "arm's-length bodies" including the Care Quality Commission, NHS England, NHS Improvement, Public Health England, and the National Institute for Health and Care Excellence face having any statements on Brexit vetted and censored by the Department of health to ensure they are in line with the "top lines from the core EU exit script."

Statements will have to be cleared by the Department before publication, according to a memo seen by the *HSJ*. This represents a tougher restatement of the edict in February, again publicised by the *HSJ*, demanding that "every piece of communication, from an email to suppliers, a letter, press notice and, in this case, texts and phone calls to the public, need to be flagged, and cleared" by DHSC director of communications Rachel Carr and her team.

The *HSJ* reported back then on the immense bureaucracy and delays created by this heavy censorship of regular communication to ensure that only the government's views are expressed:

"The clearance process involves ALBs sending all relevant communications to named communications officers from the DHSC who then check with the department's EU Exit policy team, followed by clearance through the head of EU exit communications and ministerial private office, according to the email.

"Communications which need clearance by ministers are sent to them at 12pm each day. Anything which needs clearance by the DExEU takes an additional two days."

More worrying, Sky News has also revealed that the government has issued hundreds of gagging orders (legally binding non-disclosure agreements) to help cover up the actual state of play in many sectors, including 26 to keep a lid on problems at the Department of Health and Social Care.

It seems Johnson's government will devote its main energies to suppressing information and discussion of the problems their own policies are creating.

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In denial

The one substantive government report on the likely post-Brexit disruption that has been leaked to the media, the Yellowhammer report, was immediately dismissed as hopelessly out of date by ministers: but experts and eagle eyed reporters such as the BBC's Faisal Islam have shown it to be very recent, and the *Sunday Times* which leaked it reported it was compiled in August.

But as Labour leaders and public health expert Professor Martin McKee have since argued, if the document really is out of date, ministers should publish the new one to reassure health staff, patients and the public that the problems it identifies – not least on the complexity and time constraints of importing medicines from the EU have been addressed.

Suspending parliament to push a no-deal Brexit would be catastrophic for patients

Statement from TUC and 10 health unions

Together we represent more than a million health and care staff.

They're the lifeblood of our health service, consistently going above and beyond to make sure we can all rely on world-class care when we need it most.

A no-deal Brexit could devastate the NHS and social care. And if this government goes ahead with it, health and care workers will be on the frontline.

As the Yellowhammer report makes clear, a no deal could cause significant disruption to the supply of medicine, lasting up to six months.

Many medicines, including life-saving agents for cancer diagnosis and therapy, cannot be stockpiled and for those that can, stockpiles could run out.

These kinds of shortages and delays can be fatal. No responsible government should take that risk.

We have already seen thousands of EU staff leave since 2016. In the event of a no deal, tens of thousands of NHS and care workers from the EU would be left in limbo, intensifying the largest staffing crisis in the services' history.

Ministers must unequivocally guarantee the right of European health and care staff to continue to live and work in the UK.

Finally, we know that the stronger our economy, the more funding we can dedicate to the NHS and social care.

Treasury assessments show that a no-deal scenario would shrink our economy by £90bn, reducing the money available for the NHS and other vital public services.

After a decade of austerity, health and social care budgets across the country are under immense pressure.

With many care providers already in difficulty, a hit to the public finances could have additional knock-on consequences for the NHS.

With waiting times rising, operations being cancelled and yet another winter crisis looming, the health service cannot weather a long-term economic shock.

We call on the government to take no deal off the table.

Frances O'Grady, General Secretary, TUC
Dave Prentis, General Secretary, UNISON
Dr Chaand Nagpaul, Council Chair, British Medical Association
Donna Kinnair, Chief Executive and General Secretary, Royal College of Nursing
Gill Walton, General Secretary, Royal College of Midwives
Tim Roache, General Secretary, GMB
Gail Cartmail, Assistant General Secretary, Unite
Karen Middleton, Chief Executive, Chartered Institute of Physiotherapy
Richard Evans, Chief Executive, Society of Radiographers
Sam Aitkenhead, General Secretary, British Orthoptic Society
Annette Mansell-Green, Head of employment rights, British Dietic Association

New round of moves to downgrade A&E services

John Lister

It has taken some time for some of the cutbacks proposed by the Sustainability and Transformation Plans drawn up behind closed doors in 2016 to percolate through, but a new round of downgrades and cutbacks in Accident & Emergency services appear to flow from the need for massive savings – and from the continued chronic failure of government or NHS England to tackle the growing shortages of nursing and medical staff.

Indeed staff shortages are the convenient excuses put forward for fresh efforts to downgrade A&E departments in Tyneside, Lancashire, Gloucestershire and Cambridgeshire.

South Tyneside

In **Tyneside** the Northumberland, Tyne, Wear and North Durham STP set out plans in response to a claimed £641m gap in the health system by 2021: NHS staff, unions and campaigners warned of concerns that

"… with references throughout the STP to the need to reconfigure services and the problems sustaining seven acute hospital sites, that **the South Tyneside FT and Sunderland FT coming together to be managed under a single management could be a prelude to a merger in which one hospital or the other would be downgraded** – leaving patients from the other area to travel much further for treatment."

The two trusts have merged, and now, as predicted, the pressure is on to strip out services from South Tyneside Hospital to "centralise" them in Sunderland.

Some stroke, paediatric and maternity services have already been moved to Sunderland – but more services are at risk: the next phase of the so-called "Path to Excellence" scheme involves changes to emergency care, surgery, diagnostics and outpatient services, effectively downgrading South Tyneside to an elective treatment centre with urgent care.

Since 5th August children's A&E services in **South Tyneside Hospital** have been closed between the hours of 10pm and 8am: this will affect 3,600 children a year. Senior consultants in the trust report that the numbers of children attending A&E almost quadrupled from 6,000 in 2012 to 21,000 in 2018. Every cutback further undermines the hospital's future as a District General Hospital.

The only reason holding up this next change is the shortage of capital. But astoundingly it seems that local councillors could step into the breach and enable the trust to go ahead. Ken Bremner, chief executive of the merged Trust, has said if NHS funding is not forthcoming local councils could offer support to the scheme.

In July campaigners took to the steps of South Shields Town Hall to protest at the possibility of South Tyneside and Sunderland councils using their borrowing powers to raise up to £50m capital … to fund changes that would further cut back their own local hospital services. The lion's share could come from South Tyneside Council.

Save South Tyneside Hospital campaign chair Roger Nettleship warns that the main reason for this is because NHS chiefs "want the council to buy-in to this second phase without knowing what it's going to be. If they buy into it, then they're most likely to not oppose the services that will be lost. The scrutiny committee did a brilliant job to oppose the phase one when they referred it to the secretary of state. There won't be that same impetus to do that if they're funding phase two."

Staff shortages are the convenient excuses put forward for fresh efforts to downgrade A&E departments in Tyneside, Lancashire, Gloucester-shire and Cambridge-shire

Chorley

In **Chorley in Lancashire** the process of downgrade of the Chorley and South Ribble District Hospital is more advanced: its A&E closed completely for much of 2016 citing staff shortages, and depite the efforts of campaigners is now functioning only for limited hours.

A new document assessing 13 options for the future of hospital services in Chorley and Preston was published on August 22, but while it claims to be "clinically led" it notes (pages 9-10) that its preferred options have been precluded by a lack of capital and the financial plight of the trust which ended last financial year £46m in the red.

The report concludes it's not "clinically viable" to retain accident and emergency facilities at Chorley: but "It is clear from high-level clinical activity modelling that the population health requirements could not be serviced by one of the two current hospitals" – and there is no money to build a new hospital or expand either to cope.

Of the 13 options only one, Option 3, includes reopening services which have already been closed at Chorley - emergency surgery, inpatient paediatrics services or obstetric-led services: it's clear that this is not the favoured option, and others continue the downgrade of the hospital. The report warns:

"As a programme, we recognise that some of the options described in this paper may be difficult for some people to accept. The changes proposed will be difficult, but it is necessary to resolve the issues that we described in our Case for Change."

The cutbacks at Chorley have had knock-on effects on surrounding hospitals as far away as Bolton. Earlier this year Preston Hospital consultants, part of the same Lancashire Teaching Hospitals Foundation Trust as Chorley, wrote to trust executives and used social media to raise concerns about its struggling emergency services, which have been among the worst performing in England against the four-hour target.

Hinchingbrooke

In **Cambridgeshire** the first steps towards downgrading A&E services at **Hinchingbrooke Hospital,** which has been merged with Peterborough 24 miles

away into the North West Anglia Foundation Trust, have begun – despite repeated categorical assurances during the merger in 2017 that services would remain on existing sites, and that merger was the only way of maintaining A&E at Hinchingbrooke.

The financially-challenged Cambridgeshire & Peterborough STP is now proposing to close all trauma services at Hinchingbrooke, forcing patients to travel either to Peterborough or Addenbrooke's hospital in Cambridge, 23 miles way. This removes a key component of the A&E service, and will strengthen local concerns that it could be further downgraded, using the pretext of staff shortages.

Cheltenham

West County ITV reported at the beginning of August that **"Plans to close Cheltenham's A&E department"** had been confirmed by the town's MP.

Conservative MP Alex Chalk warned that the proposals would downgrade the accident and emergency department to an Urgent Treatment Centre, and set up a petition against the changes. He said that it was a "bad proposal" and "a flawed way of engaging about it".

Three days later, after the level of public anger became obvious, and as the political situation made an impending election more likely, ITV announced what appears to be simply a temporary reprieve: "Safe for now? Plans to close Cheltenham Hospital's A&E service have been delayed".

This has to make us wonder about political strings being pulled: how long will the reprieve last? and how many more downgrades are waiting in the wings?

West Midlands Ambulance loses contract

CCG ditches top quality patient transport service

Samantha Wathen, Press Officer and writer for Keep Our NHS Public

West Midlands Ambulance Service has been passed over in favour of private company E-zec to deliver non-emergency patient transport in Worcestershire, putting 80 jobs at risk, in a contract the WMAS Trust has held for 30 years.

This decision, one of a long and inglorious line of decisions by CCGs across England to privatise PTS services, with frequently disastrous results, has raised suspicion that it is nothing to do with performance, and everything to do with cost.

WMAS was the first ambulance trust ever to receive an 'outstanding' rating from the CQC, and this has just been confirmed for another year. The problem was that this quality service is more expensive than a poorer service. WMAS non-emergency service operations delivery director Michelle Brotherton said:

"We acknowledge that our bid fell outside the financial envelope set by the Commissioners, but we are simply not prepared to put patient care at risk."

Speaking to the BBC she added: "we know.... we would be unable to deliver a safe service and ensuring that we were meeting all of our performance targets within the financial cap that was put on the contract."

E-zec has not confirmed if it will keep the patient transport service based at stations in Kidderminster, Bromsgrove and Worcester. UNISON's regional organiser Chanel Willis said:

"We are all deeply shocked at the decision to award the contract to a private company. Many questions have yet to be answered – primarily where staff will be based. Staff have been in tears since the announcement and are devastated that the decision may affect patient care and their livelihoods."

Justifying the decision, a spokesperson for Herefordshire and Worcestershire CCGs said:

"The procurement process was robust to ensure the new NEPTS provider is able to deliver against the contract's quality and performance requirements. The process was weighted on patient quality and safety over financial considerations."

As The Lowdown reported earlier, since June 1 E-zec has also been responsible for providing non-emergency patient transport in BaNES, Swindon and Wiltshire (a 10-year contract worth around £80m) with the CCG publicly giving the same assurances over a robust procurement process.

However, the response to a recent Freedom of Information request submitted to Swindon CCG by the Swindon branch of Keep Our NHS Public suggests the motivation for their decision making was primarily based on cost:

"CCGs undertook a robust and legally-compliant competitive tendering procurement process...E-zec was awarded the contract on the basis of having the most economically advantageous tender"

Last year, the Care Quality Commission criticised the E-zec service in Bristol saying there was no evidence staff references had been received or reviewed, staff were not trained to carry out driving duties safely, bosses were unable to say if mandatory training had been completed and key targets were not always achieved.

In Swindon the previous provider, Arriva were not retained due to poor performance so subsequent due diligence processes should have been especially rigorous.

However, even a cursory Google search of E-zec reveals an alarming number of what appear to be damning reviews from both staff and patients, some of which include allegations of unsafe driving poor cleanliness and a bullying culture amongst workers.

In reality it is therefore debatable just how rigorous the checking process was, or indeed how high the bar is set on previous performance.

A second FOI submitted by Swindon KONP in July asked for details of patient complaints since the beginning of the contract in June. The answer revealed transport had failed to turn up for an end of life patient, whilst another palliative patient was wrongly refused the service.

E-zec currently holds 11 NHS contracts with various clinical commissioning groups and NHS Trusts across the UK. In Suffolk the company had missed three of its four performance targets every month this year up to March (when the most recent data was released)

When accused of putting cost-saving before quality CCGs have said there is little option available to them when budgets are tight.

A Swindon KONP spokesperson summed up campaigners' views, stating: "E-zec's performance to date provides a perfect example of why inept profit-making companies should not be running NHS services, and CCGs should not be enabling them."

E-zec has not confirmed if it will keep the patient transport service based at stations in Kidderminster, Bromsgrove and Worcester

Johnson 'cash-bombs' the electorate – with fictional NHS funding increases

John Lister

In the month since our last issue was published we have seen the appointment of Boris Johnson as Prime Minister after a vote by Tory Party members, and the formation of a new cabinet composed only of ministers willing to toe the Johnson line, whatever that might be. Among them is Health and Social Care Secretary Matt Hancock.

There has also been a change in advisors shaping the decisions of the new PM, chief among them being Dominic Cummings, who orchestrated the Vote Leave referendum campaign. Johnson's health advisor is former McKinsey man Will Warr, who has little if any background in health, but nonetheless argues "more money is not the solution" to transforming the "hopelessly ill-equipped" NHS from "the monolith we have today," and is even more fanatical than Matt Hancock about the use of technology and apps to replace health care as we know it.

Soon after selecting his cabinet Johnson began making announcements about the NHS which have proved to be misleading. In early August news media trumpeted the story that he had "announced a one-off cash boost of £1.8 billion for NHS hospitals in England – about a tenth of the extra £350m a week the Leave campaign and the famous bus promised would flow to the NHS after Brexit.

The BBC and others loyally repeated the government claims that this was "money coming from the Treasury, and is not a reallocation of funds from the Department of Health".

The *Sunday Times* more accurately described the purpose behind Johnson's new policy as seeking to win electoral support, headlining "Boris Johnson drops £2bn NHS 'cash bomb' to woo female voters."

But within hours this story started to unravel: just £850m could be claimed to be extra spending, and this is far less than the billions that have been squeezed out of hospital budgets in so-called savings in recent years.

The day after Johnson's announcement, Nuffield Trust analyst Sally Gainsbury, who had immediately questioned the "new money" on Twitter, explained in the Guardian how the better-placed trusts had been persuaded to cut back on spending and run surpluses to help cover deficits elsewhere, and promised this would mean they could spend extra money on capital investment:

"Then came the catch. The Department of Health was happy to bank the trust efficiency savings …. But when it came to trusts actually spending the cash they had earned through the scheme, the department realised it would bump into the Treasury's cap on investment spending."

As recently as July NHS England wrote to trusts demanding further cuts, reducing their capital spending plans for this year by 20% – equivalent to about £1bn.

As a result, Gainsbury argues: "For this year at least, what the prime minister's announcement really means is simply reversing the broken promise made to trusts when they cut their costs in return for cash they were told they could spend."

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Within hours the story started to unravel: just £850m could be claimed to be extra spending – far less than the billions that have been squeezed out of hospital budgets in so-called savings

That same day Chris Hopson, the chief executive of NHS Providers, the membership organisation for NHS trusts, agreed that health think tanks were partly right to argue more than half of the money was not new: "some of the extra 2019-20 capital expenditure enabled by this announcement will be funded through cash surpluses currently sitting on provider balance sheets. That spending can legitimately be described as money that trusts already had, but were told they couldn't spend and are now able to spend."

Whether or not the money is new, it's also only a fraction of what it would really cost to upgrade 20 hospitals, according to Nuffield Trust boss Nigel Edwards, who described the money as "a welcome down payment on the staggering £6 billion needed to clear the backlog of NHS maintenance."

The scale of the problem is underlined by the news as this article is written that two NHS trusts have had to close 170 beds, and in one case ensure hourly fire inspections because of unresolved fire safety issues requiring capital spending.

Shadow Health Secretary Jonathan Ashworth was not only critical of the amount on offer but sceptical, pointing out that since 2017, 145 new spending schemes for hospital beds, buildings, medical equipment and information technology have been announced, totalling £2.5bn: but only 3 percent (less than £100m) of these schemes had actually been delivered. 'We will see if this money is ever delivered.'

Anita Charlesworth of the Health Foundation criticised Johnson's approach from a different angle, arguing that "the NHS urgently needs money to upgrade facilities. But capital investment must be driven by what patients need, and as part of a coherent strategy — not piecemeal announcements that make good headlines."

With debate still raging over the bigger announcement, Johnson followed up with another swiftly discredited, but much smaller promise, of an "extra" £25m for hospices on August 20, which was shown the next day by the HSJ not to be new money at all.

Three days later Johnson was again keen to cash in on the NHS as a vote-winner, making sure pictures of him with celebrity chef Prue Leith were linked with the re-announcement of the review of hospital food that had been set rolling by Matt Hancock in June after patients died of listeria after eating infected sandwiches. Johnson further alarmed cardiologists with the suggestion of feeding patients "hot buttered toast".

The Daily Mail swiftly afterwards revealed that Leith's son Danny Kruger is Johnson's secretary and fixer in Downing Street, while other news media looked back at the £50m-plus wasted on various previous headline-grabbing efforts to enlist celebrity chefs to help improve hospital food, all of which have foundered on chronically low funding per meal and the lack of hospital kitchens.

So if we can't trust Johnson to speak the truth on relatively small sums of money or deal seriously with problems of hospital catering, can we rely on his commitment, or those of his ministers not to include the NHS in trade talks with the USA after Brexit?

And what does his henchman Jacob Rees Mogg mean when he says on Radio 4 that the government will "bring forward legislation on the NHS"?

Bradford strikes force a pause ...

Support staff fighting Bradford Hospitals trust plans to hive them off to a "wholly owned company" have paused what would have been indefinite strike action.

In last minute talks brokered by ACAS, the Hospital Trust has agreed not to proceed with its plans to transfer all staff out of the NHS on October 1.

UNISON has instead been given the right to address the whole management board on September 12, and the Board will respond to UNISON by the end of the month. If they decide to continue with their plans, the earliest they can now proceed will be February 2020.

After three weeks of action so far, many staff are facing financial hardship, and they are still in need of funds. Donations to the crowd-funding appeal can be made online.

CQC forces closure of mental health unit

Child and adolescent mental health services in a North East Foundation Trust where two girls died in two months have been closed as the result of enforcement action by the Care Quality Commission.

The service is comprised of five units across West Lane Hospital, West Park Hospital and Roseberry Park. The units at West Lane Hospital in Middlesbrough have been closed, and 32 young people have had to be shipped to other units, which are likely to be crowded and further from their homes.

The CQC's enforcement action followed on concerns raised by inspectors at the trust in June 2019, which were confirmed by a return inspection on August 20 and 21, although the report identifying the most recent findings has not yet been published and will appear "in due course".

The June report, which the CQC says was "prompted by concerns raised about the treatment of young people receiving support, low staffing, a poor culture and a significant number of self-harming incidents at West Lane Hospital" noted a marked deterioration in services that had been rated Good overall, and Good for safe, effective, caring and well-led services only a year previously.

This time child and adolescent mental health wards were rated Inadequate overall and for safe, responsive and well-led services, and Requires Improvement for caring and effective services.

The CQC noted a marked deterioration in services that had been rated 'Good' overall only a year previously

Staff told the CQC that staffing was insufficient to support the complex needs of the young people using the service.

There have also been allegations of staff ill-treating patients, and using inappropriate techniques for moving patients. Middlesbrough Labour MP Andy McDonald told the BBC that the CQC action was evidence of a systemic failure.

Meanwhile the lack of government commitment to address desperate lack of resources in child and adolescent mental health is illustrated by a recent press release trumpeting the relatively trivial allocation of £3.3m across local projects to help prevent mental illness in children and young people.

The Local Government Association has called for a complete overhaul of children's mental health services to ensure young people receive better care and support.

The LGA is calling for more government funding and resources to ensure early diagnosis for children.

The councils argue that councils have had to use their own reduced budgets to pay for services to plug the gap to get young people the urgent treatment they require, while fragmentation and in the system forces young people and their families into a complex struggle with multiple practitioners and agencies.

IEA: a well-connected right wing think tank, paid to reject the NHS model

John Lister

Few weeks go by on the broadcast media's main "news" programme without an intervention from at least one spokesperson from the "Institute for Economic Affairs". However not one of the interviewers ever bothers to press the question of exactly who they are, and who funds them and their rabid neoliberal views, which include rejection of the NHS as a publicly funded and provided service, and opposition to the "sugar tax" and any attempt to combat the obesity epidemic by curbing the "freedoms of the giant food monopolies.

The IEA is technically is an "educational charity," but in practice operates as a consistently right wing think tank. It was founded in 1955, and according to Margaret Thatcher after her election in 1979 it "created the climate of opinion which made our victory possible".

As a reservoir of neoliberal ideology one of its natural targets for attack is the NHS, which the IEA dismisses as "one of the most overrated, inefficient systems in the world". Its ferocious promotion of a hard Brexit led to an IEA report being sharply criticised earlier this year by the Charity Commission for its obvious bias, given the organisation's status as a charity.

IEA has consistently refused to divulge any details of its funding, despite strong suspicions that much of it comes from overseas.

However recent research for the BMJ revealed that a significant sum comes from the tobacco industry:

"the organisation is part funded by British American Tobacco. In the past it has also taken money from the gambling, alcohol, sugar, and soft drink industries."

As recompense for this financial support, the IEA has stridently opposed public health measures for tackling smoking, obesity and harmful drinking.

Its website admits to annual income of £1.9m, and says it has between 11 and 50 staff. The only detail it has given on its funding is to admit in 2017 "its income of £2m came primarily from unnamed "foundations and trusts" (23%), "large businesses" (23%), and "individuals, entrepreneurs and family firms" (20%)."

The BMJ investigation includes an infographic plotting the IEA's financial links to 32 Tory MPs, and argues that the MP most closely and publicly associated ideologically with the IEA is one-time Tory leadership candidate Dominic Raab.

The BMA study also reminds us that although he "does not have direct links with the IEA", health secretary (and another failed Tory leadership candidate) Matt Hancock has in recent years received funding [totalling £32,000] from Neil Record, who became chair of the IEA board of trustees in 2015.

The IEA is also well-enough connected to secure ready and frequent access to national media coverage, especially through the many well-placed right wing editors at the BBC, while those with opposing views to the IEA seldom get a look in. Its young American associate director Kate Andrews has become a regular interviewee or participant in various news-based outlets, especially the BBC.

A professional 2-minute video of Andrews summing up the IEA's view that after 70 years "It's time to overhaul the NHS and replace it with a system fit for 2018" was produced by Newsnight.

Essentially the IEA rejects the basic structure and values of the NHS, and advocate insurance-based models. Their criticism of the NHS basically always reiterates the same points, so it's worth examining the accuracy and relevance of the claims made.

Andrews always works to the same basic list of countries whose systems she points to as more effective and preferable to the British NHS. The list includes Australia, Belgium, Netherlands, Germany and Switzerland.

All of these countries spend much more money per head of population than the UK. According to the latest OECD figures, **Australia** spends 12% more per head; **Belgium** (never cited by anyone other than the IEA as a model health care system) spends 15% more; **Netherlands** 28% more, **Germany** 32% more and **Switzerland** – one of the highest spending countries after the USA – 89% more per head than the UK. And of course the UK average is higher than spending in England.

Significantly increased levels of spending facilitate increased investment in staff, and in diagnostic equipment. The UK also has **less than half the OECD average provision** of MRI scanners, and **less than a third of the OECD average of CT scanners** (only Hungary and Mexico have lower provision). These are key in early detection and treatment of cancer; but a common criticism of the NHS by the IEA and similar organisations is that other countries outperform us on treatment of cancer.

Another factor in our lower spending is the low level of provision of nurses and doctors, where the UK is well below all of the IEA's chosen comparisons. Our provision of hospital beds is 4th from the bottom of all the OECD countries. This same point has been widely raised, for example by a recent Nuffield Trust report.

The IEA dismisses and ignores the US-based Commonwealth Fund's comparison of 11 different health care systems, which has consistently ranked the UK as the best overall performer despite the relatively limited spending. Belgium is not included in their comparison, Australia comes second to Britain, Netherlands third, Switzerland sixth and Germany eighth.

The Commonwealth Fund study, which also has significant weaknesses, is based on five key measures – Care Process, Access, Administrative Efficiency, Equity and Health Care Outcomes. The UK comes third on access and efficiency, tenth on outcomes, but top on care process and equity – largely because of the way in which it has been structured without up-front charges for care.

These issues are of no concern to the IEA. While it claims its favoured models give "universal access", its preferred systems are all very different, highly complex social insurance systems with much higher levels of charges for treatment.

"the organisation is part funded by British American Tobacco. In the past it has also taken money from the gambling, alcohol, sugar, and soft drink industries."

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Switzerland is one of the wealthiest countries in Europe, yet the proportion of private 'out of pocket' spending on health is exceptionally high at 26% of total health spending. This means that low and middle income households pay a higher proportion of their income for health care than the richest.

Swiss patients wanting health care have to pay a "deductible" (fixed amount to be paid before insurance cover begins to reimburse costs) as well as a copayment (a percentage of the cost of treatment) which cannot by law be covered by insurance.

There is a £12 per day fee for hospital inpatient treatment. Mandatory health insurance does not cover 90% of dental costs, or some outpatient treatment such as psychotherapy.

Far from giving the same coverage or better than the NHS, the Swiss system is more expensive for individuals and much more unequal.

In **Germany** health budgets are controlled by an immense bureaucracy of 132 different "sickness funds:" but the system is not a universal one covering all citizens. There is a separate system of insurance for the highest paid (earning above €4,050 per month). These people with above average wealth also tend to have above average good health.

Separating them out so they do not contribute to the costs of health care of those on lower incomes, allows them to pay lower contributions, despite entitlement to higher benefits. This means that the population with least means and highest risk of ill health are left in a separate system. This is very different from the British system based on progressive taxation.

The IEA is very keen on the **Belgian** system, but the whole Belgian population, 10.7 million, is not much bigger than London. However one very striking difference is that the Belgian health budget is fixed by legislation which requires it to grow in real terms each year.

If this applied to the UK, our health spending would already be significantly higher, after 9 years of austerity levels of funding. Belgium also has far higher costs to individual patients than the British NHS.

The **Australian** government subsidises private health insurance, spending $6 billion every year to give tax breaks to those with insurance, even though private treatment costs are notoriously inflated and the same money could open far more public sector hospitals and improve the service to all. As in so many countries it's the publicly-funded hospitals that carry most of the burden of emergency and complex care.

The **Netherlands** system scores highly in many comparative studies, but it is one of the most expensive, seventh largest spend per head. The complex combination of mandatory and voluntary health insurance also means that costs fall disproportionately on low and lower-middle income individuals, who end up paying between 20-25% of their income in healthcare costs: this is far less equitable than the UK system. Competition has increased the bureaucratization of the healthcare system, with over 1400 different insurance packages, making choice for consumers extremely complicated.

More recently the IEA has begun to throw in some completely different examples, such as Hong Kong and Singapore, which again are very different systems for small populations.

Hong Kong has a population of 7.3 million – less than London – and a health care system that is funded from general taxation – but at a rate of 6.1% of GDP (just over £2,000 per person), so the health budget does not cover all of the costs of the service. As a result there are user fees for hospital care, including emergency care. In addition the under-funding and inadequate provision of hospital care means there are long waiting times for treatment, with delays of up to 20 hours for emergency admissions, from 36 to 110 months wait for a joint replacement, and a six month wait for outpatients – much worse than the NHS. There is a developed private hospital network, but the charges are prohibitive for the poorest.

Singapore is an authoritarian city-state, with an even smaller population (5.6 million), and spends just 3% of its GDP on health. It does not offer universal or comprehensive health coverage: unlike the NHS, services are only subsidised from general taxation, and subject to means tested charges, with no annual cap on out of pocket spending.

Hospitals advertise their charges so that patients can decide whether or not they can afford to access treatment. In 2013 more than two thirds (69%) of Singapore's health spending was private spending, and the vast majority of this (88%) was out of pocket spending by individuals, the most regressive way to pay for health care.

Copayments, deductibles, and restrictions on the uses of health insurance schemes (Medisave and MediShield) to cover costs of consultations, treatments, and procedures are all designed to discourage unnecessary doctor visits, tests, and treatments and keep health care "demand" in check. However each of these has greatest impact on people on the lowest incomes who are also most likely to suffer illness and need health care.

So it's clear the IEA consistently favours high cost, insurance-based schemes with significant spending on bureaucracy.

They pay no regard to the impact of user fees on the poorest, and seem unconcerned with the need for universal or comprehensive services.

Perhaps most important, they are quite happy to criticise poor outcomes from the British system without discussing the very substantial additional cost – to government and to individuals and their families, especially those who would face hefty charges – of changing over to any of the IEA's preferred models.

What the (research) papers say

JOHN LISTER looks at three recent academic papers and a book relevant to NHS campaigners

Health inequalities – don't forget the politics!

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The importance of action to address the causes ("social determinants) of ill health and improve public health as part of any plan to improve and expand the NHS is widely accepted in words, and a crucial assumption of the NHS Long Term Plan in England, so any books or articles that remind us of the health consequences of austerity and inequality must be welcomed.

This summer has seen not only another interesting free access article demonstrating the impact of financial crisis and austerity on health in Andalusia, but also open access to an entire 290-page book on Health in Hard Times, focused on the British context and in particular the north east of England.

Both make important points and remind us of some of the long term effects of austerity as a policy option implemented by governments. But both also have surprising weaknesses.

The study on Andalusia, the large southern region of the Spanish state that suffered especially brutal repression under General Franco's fascist rule published in the *International Journal for Equity in Health*, notes that it was one of the regions most damaged by the economic crisis triggered from 2008 by the banking crisis.

The impact was exacerbated by the subsequent brutal austerity regime imposed on Spain, as well as Ireland, Portugal, and most infamously Greece by the "troika" of the European Commission, the European Central Bank and the International Monetary Fund.

Andalusia faced a much heavier reduction in health budget than other regions of the Spanish state (13.9% compared with an average of 9%) as well as closure of several services, loss of hospital beds, the axing of over 7,000 health care jobs, the imposition of co-payments for prescriptions for pensioners and those on high-incomes, and changes to the health care system to make coverage dependent on social security contributions, ending NHS-style entitlement based on residency.

Waiting lists for treatment have grown, the quality of care has fallen, primary care and prevention have been cut back – at a time when falling living standards and growing unemployment was also undermining public health. The study reports on interviews in which people from different social layers – the poorest and most vulnerable, the middle class and "upper social class" express their experience and reaction to the changes that have taken place.

For the poorest, the focus is much more on survival: access to a basic diet and their ability to afford medicines, especially for children. For the middle class the preoccupation is much more focused on mental health, the increased pressures, and the lack of resources in health care.

Andalusia lost 13.9% of its health budget compared with a Spanish average of 9%, and over 7,000 health care jobs

By contrast the wealthiest groups "did not consider that the crisis had directly affected their health, yet they were very aware of how it had impacted Andalusian society in general."

Missing from this interesting account is any mention of one of the more discriminated against and vulnerable communities in Andalusia, the marginalised Gypsy population whose limited access to education and employment increases their need for assistance from the State health service – or indeed any discussion of ethnic minorities.

Nor, in a region which in January saw an end to 36 years of socialist control and the establishment of a new right wing government propped up by the far right, is there any discussion of the ways in which regional government action might have addressed some of the problems, or now make them even worse by further cutting taxes (and thus government revenue), further reducing welfare benefits and support for disabled people, and further increasing levels of discrimination.

Similar weaknesses also spring out from the new book Health in Hard Times, even though its Foreword promises to provide "a vivid illustration of how health inequalities are largely the result of political choices."

The book is edited by Clare Bambra, Professor of Public Health at Newcastle University, who summarises it on Twitter as demonstrating "the impact of austerity on health inequalities using mixed methods research". It seeks to go beyond limited analysis of inequalities based either on the composition of the local population or the specifics of the geographical context to bring in political-economic factors and a historical view. In doing so it offers a wide range of useful and alarming information, identifying the impact of key measures (p13).

The book is primarily focused on just one north east town, Stockton on Tees. We learn that there is a staggering 15-year gap in life expectancy between the most and least deprived areas of the town, which are just two miles apart. Stockton in this respect is typical of some of the more deprived areas of the north of England, where as one new campaign has pointed out "over half of the North has a lower life expectancy than the worst area in the South."

But in other ways Stockton is very untypical. In particular, along with much of the north east it has very low proportion of non-white residents: ONS figures show that it has less than half the English average of Asian and British Asian population, around a quarter of the English average of Black or Black British, almost 10% fewer non-white people. The book's focus on this one town means that scant attention is paid to the health impact of health inequalities and racial discrimination on ethnic minorities.

A focus on just one town also serves to understate the scale of the problem, which is especially acute in Britain, but a wider issue across Europe: "European Union-level analysis suggested that the costs of health inequalities amounted to EUR 980 billion per year, or 9.4% of gross domestic product (GDP) – as a result of lost productivity and health care and welfare costs.

"… Analysis has also suggested that increasing the health of the lowest 50% of the European population to the average health of the top 50% would improve labour productivity by 1.4% of GDP each year – meaning that within five years of these improvements, GDP would be more than 7% higher." (p247).

However this also highlights an elephant in the room which the entire book ignores: despite Stockton's massive vote to leave the EU, along with much of the north east, the word Brexit appears only once in 290 pages, and the issues it poses are not addressed at all – even in a book published in June 2019, amid mounting public and media concern over the dangers of a no-deal Brexit.

The likely post-Brexit recession would impact very heavily on the economy of the Brexit-voting north east and therefore once again on the health of its people.

And despite repeated reference to political economy, there is very little explicitly political assessment, even though it's clear that action on any scale sufficient to address health inequalities requires a full scale change of government and policy – from actively making things worse since 2010, to seeking to address problems that have been created.

Clare Bambra and colleagues know it is not an accident that levels of child poverty and homelessness have increased since 2010, and are far worse overall in the north than the south. The book states several times that austerity policies are a choice and not an inevitability. But it pulls its punches.

The book states several times that austerity policies are a choice and not an inevitability.

The lack of any current political analysis and the silence on Brexit underline the fact that, with the partial exception of Clare Bambra's concluding chapter, much of the book also reads as already seriously out of date, although this is possibly a result of publication delays rather than all of the chapters coming from academics.

Much of the information in the edited chapters that make up the majority of the book appears to rely on relatively dated references, not least a useful list of reactionary "welfare reforms" from 2010, which sadly ends prematurely in 2015 (p14).

However the book gives useful information, it's well-researched, and it's free to access.

Hospital chez vous?

"Hospital at home" (HAH), like mergers and reconfiguration, is a concept that is often trotted out by NHS bosses in England, although they tend to be stronger on the long term promise than on the actual delivery of services.

Few NHS commissioners or providers pay much attention to the aspect of "hospital at home" that has been investigated by another free access paper in The experience of patients and family caregivers during hospital-at-home in France.

It shows that HAH is already established as a significant factor in French health care:

"HAH is a model of care that provides acute-level services in the patient home and can also in some cases be set up in a nursing home. HAH is a less expensive way than conventional hospitalization with an average cost of 198€/day in the French health system."

41% of French HAH providers are public sector, 41% non-profit, and the remainder is provided by profit-seeking companies. HAH accounted for 4.6% of the total of bed days in France with payments totalling €913 million to 308 HAH institutions in 2015.

Can we, ethically, favour patient's well-being over caregiver's suffering?

The study uses interviews with patients and caregivers, all in the Paris area. It found that "HAH remains widely unknown among patients and caregivers, who rarely are at the origin of the admission, and lack information before the return home."

It reveals some of the stresses and strains on caregivers, pointing out that the extra work could lead to a real deterioration of their relationship, but also of the caregiver's health. The study raises a "fundamental" question that needs to be asked of the NHS:

"Can we, ethically, favour patient's well-being over caregiver's suffering? If HAH is beneficial to patients but strongly impacts caregivers, should we deprive the patient from a better care to relieve the caregiver? Or should we force the caregiver to bear the situation in the name of "good care"?"

Nordic health emergency

Another free access paper giving an interesting sidelight on problems we face in England comes from Norway. Emergency department crowding and length of stay before and after an increased catchment area takes a familiar story: the merger of four hospitals on the outskirts of Oslo to form Oslo University Hospital, followed by closure of some of the previous capacity, including (unlike England) closing a University Hospital (Aker).

About 150,000 inhabitants which had Aker as their local hospital, were transferred to Akershus University Hospital, now the biggest emergency department in Norway.

"Thus, the catchment area of Akershus University Hospital increased by 44% from Jan 1st 2011, from 340,000 to 490,000, the latter approximately 10% of the Norwegian population." The hospital had already, been struggling with bed capacity, with a high bed occupancy level.

The study reminds us NHS commissioners and their management consultants do not have a monopoly on half-baked plans. In Norway, too, inadequate resources lead to delays: length of stay (LOS) increased by 20.9% as admissions increased by 41%, with neurology admissions up 46.5%.

"Even after 5 years, the LOS was higher than before the expansion, mainly because of the throughput and output components, which were not properly adapted to the changes in input."

Even in wealthy Norway: "The increased catchment area … aimed to reduce costs and increase quality." However "Increased LOS and crowding is often a sign of the opposite, as a longer stay in the ED increases the risk of adverse events and decrease patient safety."

THE lowdown

Health news, analysis and campaigns.
NUMBER 9, Sept 16 2019

Informing, alerting and empowering NHS staff and campaigners

Questions for commissioners

Collapse of privatised 999 service hits NHS

One of the largest providers of 999 support in England has gone into administration, affecting a number of trusts across the country.

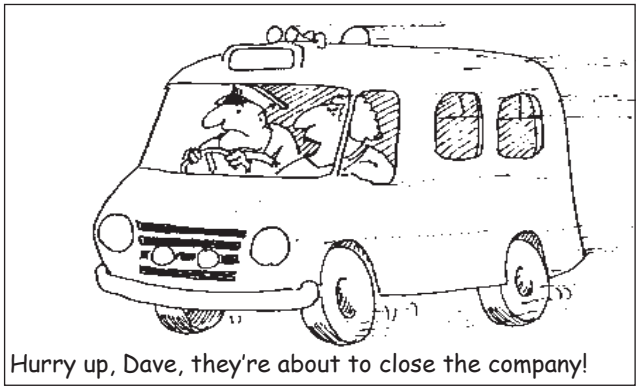
SSG UK Specialist Ambulance Support Ltd, who provided 999 emergency and non-emergency transportation for the NHS, were put into administration last week.

The company provides services for ambulance trusts all across the country including South central, East of England, North East and London.

South East Coast Ambulance Trust (SECAmb) have approached other private ambulance companies to ensure patient services are maintained, to cover the 15% of its 999 calls affected by the collapse.

The most recent company accounts for SSG UK in 2017 revealed a £250,000 net loss, but its financial position worsened over recent months, partly due to a fall in NHS work after the NHS changed its performance targets.

This story is the most recent in a catalogue of contract failures between the NHS and private ambulance companies, highlighting the insecurity associated with outsourcing these vital services.


Hurry up, Dave, they're about to close the company!

The CQC has warned against a reliance on privately run ambulance services.

Private ambulances used throughout England's NHS

At the end of August, it was revealed that the NHS England was spending upwards of £92 million in the last year on private ambulances and taxis for transporting patients. Increasingly, NHS Trusts in England are relying on private ambulances for responding to emergency calls.

Press Association research from freedom of information requests found in some parts of the South of England, 1 in 5 emergency calls were resulting in private ambulances being sent out.

The East of England Ambulance Service NHS Trust's reliance on private ambulances for emergency calls doubled in 2018/19 compared to last year, up to 26,428 call outs.

Damaging impact

In March 2019, the CQC produced a damning report that warned of patients being put at risk as a result of a reliance on privately run ambulance services. Levels of staff training varied hugely and DBS checks were not being consistently carried out.

Concerns were flagged up on staffing, safeguarding, medicine management and vehicle/equipment maintenance.

IN THIS ISSUE

Curse of PFI strikes again

The use of the 'Private Finance Initiative' (PFI) to fund new hospitals and infrastructure was a nightmare solution most famously embraced by New Labour from 2000: but the two major hospital deals signed off since the Tories took over in 2010 remain stubbornly embarrassing, costly failures.

Both the Royal Liverpool Hospital and Birmingham's Midland Metropolitan fell victim to the collapse of construction giant Carillion: work on both unfinished hospitals halted immediately, and has yet to resume. In each case the public sector is having to step in and pick up an additional £300m-plus bill for the remaining work – effectively doubling the initial cost for completing each hospital, both of which have been heavily delayed.

In Liverpool ministers have rejected calls for a full public inquiry into the scandal of a building which was not only left incomplete, but also unsafe: major sections of the work built by Carillion have had to be demolished after major structural issues were identified by the new contractors Laing O'Rourke. The trust is seeking another £300m to complete the 646-bed hospital in addition to the £76m loan to the trust to help buy out the failed PFI contract, which initially costed the new building at £335m.

In May it was revealed that the trust was having to spend £500,000 per month to look after the unused hospital, including leaving lights on 24/7 and a team running all 4,000 taps regularly to prevent bacteria building up.

Meanwhile the Sandwell and West Birmingham hospitals trust is still waiting for the go-ahead to restart building work on the Midland Met, even though a £358m contract to complete the hospital was approved by the Treasury 9 months ago.

Balance sheets propped up by huge loans

Can trusts continue as 'going concerns?'

John Lister

Mid Yorkshire Hospitals Trust's latest Annual Report (2018/19) carries a note from the Auditors warning that Mid Yorkshire Hospitals has a chronic and cumulative deficit, no plan in place to repay the accumulated deficit of £159m (almost a third of the trust's total income), no plan to return the trust to a recurrent break-even position, and relies on the expectation that "cash funding loan finance" from the Department of Health and Social Care will continue "without interruption".

On this basis the auditors note that "These events and conditions … constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern."

The auditors also report that "we are not satisfied that, in all significant respects, Mid Yorkshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019."

Same boat

Sounds scary: but it turns out that Mid Yorkshire is in the same boat as many other major trusts across the country: London's Royal Free Hospital has built up seven loans worth £243.9m, after posting its highest-ever deficit last year of £81m.

According to a recent Health Service Journal report so many loans have been issued to prop up flagging finances that "trusts' combined debts to the department reached £14 billion by the end of 2018-19."

Loans from the DHSC are now half as much again as the £9 billion of hospital assets still being paid for in over 100 PFI hospital projects, and set to cost a staggering £55 billion over the next 30 years, according to a new IPPR report, which echoes some of the findings of a recent book on PFI by this author.

Mid Yorkshire is one of many trusts that now demonstrate the problems of running both a loan and a PFI contract. Four of the ten trusts with the largest relative loans compared to income also have major PFI contracts.

Dozens more trusts have run up debts to the DHSC of hundreds of millions as they attempt to keep services going and deal with rising costs and demand for care after nine years of effectively frozen funding.

Four of the ten trusts with the largest relative loans compared to income also have major PFI contracts.

The most indebted as a share of trust income is Medway in Kent, with loans equivalent to almost 90% of annual turnover.

The ten most indebted trusts all owe upwards of 60% of their turnover (more than double the level in mid Yorkshire): but the largest debt is King's College Hospital in London which has run up a tab of £653m (capital loans of £139.6m and revenue / working capital loans of £514.2m) – equal to 59% of its exceptionally high trust turnover.

As the auditor implies, these loans are now on such a scale that they can never be repaid.

Last year senior NHS bosses actually floated the idea of writing them off; it's clear that with so many trusts so deep in the red and exceeding the "control total" limits, NHS England cannot intervene in them all, and the scale of cuts required to balance the books would be politically unthinkable even for a right wing Tory government.

So they settle for auditors adding largely meaningless critical notes to the accounts, to flag up the problem in a way they hope will not attract too much attention, and allow the loans to pile up – as a problem for any future government to tackle.

New campaign – by NHS bosses

Meanwhile NHS Providers, frustrated at the chronic failure of government to invest sufficient capital to maintain, let alone improve the NHS have launched a campaign of their own for additional capital funding.

A hard-hitting document headed "Rebuild Our NHS" points out three hard facts:

- No capital budget has been set for the NHS beyond 2020/21
- Current levels of capital spending are insufficient for the NHS' needs
- Existing mechanisms for individual NHS organisations to access capital funding do not work

It may not surprise many health workers to hear senior NHS managers pointing out that

"The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year), meaning issues like leaking roofs and broken boilers, ligature points

in mental health facilities and outdated technology cannot be fully addressed – even before any investment can be made in new buildings and services."

But many will be surprised to hear that

"Agreements for major new NHS infrastructure projects effectively ceased in 2015, when the PFI regime fell out of favour without an alternative being put in its place.

"In the case of some capital projects, NHS organisations have had to take out interest-bearing loans from the government to help finance them – even though almost half of all trusts reported a deficit in 2018/19 and will be unable to repay these loans."

NHS Providers go on to call for:

- A multiyear NHS capital funding settlement, "allowing the NHS to plan for the long term and transform its services and equipment"
- A commitment to bring the NHS' capital budget "into line with comparable economies".
- An efficient and effective mechanism for prioritising, accessing and spending NHS capital based on need.

Campaigners may not agree with all the schemes NHS Providers want to finance with the new money, but it's clear that the discontent with the present desperate lack of finance is not restricted to trade unions and campaigns.

Welsh bed closures have left hospitals short of capacity

Sylvia Davidson

Hospitals in Wales have the lowest number of beds available for patients since records began. The data from the Welsh Government shows that on average in 2018-19 there were only 10,564 beds available per day compared to 15,582 in 1996-97 and between 2009-10 and 2018-19, over 2,000 beds have closed.

Over this time, there has been a push to reduce hospital stays and increase treatment in the community, however when data such as A&E performance and bed occupancy rates are considered, it is clear that the bed reduction has had a negative effect on care.

Welsh hospitals have a very poor A&E performance - the percentage of patients who spend less than 4 hours in Welsh A&Es fell to 77.9% in June 2019 from 83.3% in June 2018; the target is 95% or more.

When bed occupancy is considered, Welsh government data shows that over the years bed occupancy rate has almost always increased year-on-year; from 78.3% in 1996-97 to 86.8% in 2018-19.

In 2018-19, the average available beds per day fell by 149 (1.4%) when compared with the previous 12 months, although bed occupancy improved slightly by 0.2 percentage points.

High occupancy rates are associated with increased infection risk, unsafe staffing levels and delays in treatment.

The Royal College of Emergency Medicine estimates that at least 250 more hospital beds are needed in Wales to return occupancy rates to below the safe level of 85%.

The Plaid Cymru health spokeswoman Helen Mary Jones claimed that there has been a "deliberate policy" of cutting beds with the main problem being the closure of community hospitals.

In 2013 cottage/community hospitals in Prestatyn, Blaenau Ffestiniog, Flint and Llangollen were closed. In other places wards have been closed, including in Llandudno Hospital. Bed closures have also taken place at hospitals in Swansea and Neath Port Talbot, with a reduction in general beds by the Abertawe Bro Morgannwg University (ABMU) Health Board of 79 beds out of 1,736 in 2017-18.

Further bed closures are planned at hospitals in Neath Port Talbot, Swansea and Bridgend in line with a policy to reduce time spent in hospital, reduce emergency admissions and shift care to community-based, according to the ABMU.

Totting up the cost of interest payments

One of the effects of propping up the finances of most NHS trusts using loans from the Department of Health and Social Security, which have in most cases already become impossible to repay, is that trusts wind up saddled with an additional chronic annual burden of interest payments.

In fact the weaker the finances of the trust, the harder it is for them to repay the loans that keep them going. Back in 2017 research by the HSJ showed that while for some interest rates were as low as 1%, the rate was much higher for the more indebted trusts, with rates as high as 6%.

£205m per year

Now i-news has published updates from Freedom of Information enquiries which reveal trusts are paying out over £205m a year in interest (which it equates to the salaries for 7,500 nurses), and that the rising annual bill stacks up to £607m over the past five years.

According to the *i,* nearly a third of the 184 trusts with loans have rates of 3.5 per cent or more, even though the Government is currently able to borrow money for a decade at just 0.7 per cent in annual interest.

Worse still these loans have been taken out after huge sums allocated to capital spending has been diverted into keeping day to day services running.

According to the HSJ three quarters of the money from land sales has also been diverted into revenue budgets.

South Tyneside campaigners win right to appeal

Eight months after an initial judicial review failed to rule against the downgrading of Children's A&E and Maternity by South Tyneside and Sunderland Foundation Trust, a judge has approved an appeal to be heard on either November 5th or 6th.

The judge said the "appeal is properly arguable and real prospect of success," although the fight now is to reverse cuts which have gone ahead in the meantime.

Problems accessing funding from NHS England have forced the Trust to postponed the further closures in Phase 2 of their plan until next year.

The Trust's attempts to get loans of £35m and £15m respectively from South Tyneside and Sunderland Labour Councils to help implement a scheme strongly opposed in South Tyneside have so far been blocked by the strength of the campaign.

The campaigners and legal experts have now been granted permission from the Court of Appeal to appeal the outcome of the judicial review and once again take their concerns about the closure of the hospital services to court.

Helen Smith, the specialist public lawyer at Irwin Mitchell's Newcastle office representing the Save South Tyneside Hospital Campaign Group, said: "Despite the conclusion of the judicial review, we have always remained concerned by the processes used to make this decision regarding absolutely vital hospital services.

"This is a hugely important issue which affects healthcare access for a great number of people in the region and it is clear that any decision should be taken with the utmost care.

"It is welcome that the Court of Appeal has allowed us to challenge the original decision and we are determined to once again ensure our clients' voices are heard on this matter."

Call for recognition of care staff skills as turnover levels increase

Laura Sanders

The All Party Parliamentary Group on Adult Social Care (APPG-ASC) says care workers deserve the same recognition as their NHS counterparts. This comes as their latest report reveals a staffing "black hole" in the sector.

They're now calling for social care to come under one nationalised council, which would oversee standards of pay, opportunities for professional development and employment agreements.

Staff turnover rate is double UK average

The inquiry found that a third of people working in care are leaving their jobs each year and of this, half are leaving in the first twelve months. Younger people or those with no formal care qualifications are more likely to leave.

Having a large number of vacancies in this sector directly impacts the NHS, as insufficient support to people who need care can lead to higher rates of re-admissions and bed blocking in hospitals.

In the West Midlands, there are currently 7,000 vacancies in social care (GMB regional figures). GMB Regional Organiser, David Warwick, says this is largely down to problems with staff retention.

He told Free Radio News that lack of staff had led one care home in Coventry to closing down because, as a result, the consistency in care to residents was slipping. He said,

"Fundamentally, we believe that the care sector should offer career progression for people that want to get into the sector, and it should offer them a career route which would improve recruitment and… improve retention of staff. And it would fundamentally improve the care for the people in the homes that need looking after."

"A demoralised, low paid workforce"

Inquiry evidence from the charity Independent Age revealed that for 20 years' experience, a care worker could expect an extra 15p per hour than someone with 12 months' experience (March 2018 figures).

At the same time, it's estimated that 500,000 care workers across the UK are being paid below the Real Living Wage (£8.21 as of March 2019).

The average wage for a social care worker is £7.89 an hour, (Skills For Care NLW 2018 statistics). In the West Midlands, the average is £7.71.

David Warwick added: "The GMB policy on the care sector is that the starting wage should be the real living wage, that there should be quality care training in place done at work, and that the ratios of staff to residents is brought up to an agreed level of safe care."

One of the advisory bodies to the APPG-ASC report, forecasts a need for an extra 580,000 social care workers by 2030 if it is to keep up with the number of people age 65 or over.

Rising demands

At the same time, Skills For Care, one of the advisory bodies to the APPG-ASC report, forecasts a need for an extra 580,000 social care workers by 2030 if it is to keep up with the number of people age 65 or over.

Workforce structure

The adult social care workforce is worth an estimated £46.2 billion, and is in fact larger than the NHS.

Whilst a proportion of social care workers are under the NHS, most are employed by one of the 21,000 organisations in the independent sector.

The report from the APPG-ASC argues that having a national body for social care providers would help to regulate pay, training and employment agreements.

Achieving parity with the NHS

Proposals for a national care Council to be introduced focus on clear pathways for professional development, and a national guideline for agreeing pay and employment in the care sector.

For care workers, this would mean greater opportunities to progress with the introduction of a compulsory accredited care certificate. In addition, a qualification package and a registration period would be introduced, and professional development would be recognised with pay.

The APPG-ASC wants this new council to be affiliated with the NHS and says it will be first step towards care workers achieving the parity of their NHS counterparts

■ The full APPG-ASC report can be found here.

Asked to make a cut too far, NHS trust chief exec resigns

After two years at the helm of South Tees Hospitals Foundation Trust, Siobhan McArdle, announced her resignation in a letter to staff.

The letter, seen by the Health Service Journal, noted that the personal cost of being an NHS CEO was too high and that the demands for cost-savings were "too great a challenge."

The letter also notes that McArdle's resignation was influenced by the "very challenging" nature of the regulatory and financial environment and that the South Tees local health economy is "underfunded and unsustainable."

South Tees is saddled with huge debts from two Private Finance Initiatives (PFI) and long-term underfunding, and McArdle notes that the trust is unsustainable without a long-term funding plan and capital investment. Something which she said her team had been fighting for continually over the past four years.

The trust has two PFI contracts - the James Cook University Hospital and Redcar Primary Care Hospital - which have 15 and 21 years, respectively, left to run and about £1 billion left to pay by 2040.

In total, the James Cook in Middlesbrough will have cost South Tees Hospitals NHS Foundation Trust £1.5 billion to build and run since it opened in 2003, with a final payment in 2034.

In 2018, the trust paid a charge of £50 million for the James Cook and £4.1 million for the Redcar hospital: each year these charges increase.

McArdle is not alone in facing a seemingly impossible challenge as a CEO of an NHS trust. Saffron Cordery, of NHS Providers, which represents trusts, said: "The concerns expressed here are not unusual. In recent years trust leaders have become accustomed to demands for productivity improvements and savings that are increasingly unachievable."

"In recent years trust leaders have become accustomed to demands for productivity improvements and savings that are increasingly unachievable."

In 2019, there were 127 PFI schemes in England for hospitals and social care. A September 2019 report from the IPPR thinktank, The Make Do and Mend Health Service, noted that hospital trusts will still have to make £55 billion in payments for PFI contracts by the time the last contract ends in 2050. An initial £13 billion in private investment will end up costing the NHS £80 billion.

A few Trusts have succeeded in escaping from these contracts, including South Tees' neighbour, the Tees, Esk and Wear Valley Trust which runs Middlesbrough's Roseberry Park mental health hospital.

In 2018, the trust won High Court battle to get out of its PFI deal.

The win hinged on the finding of numerous problems with the seven-year-old building, which resulted in patients being forced to move out. The full cost to the trust if that deal ran to its end in 2039/40 would have been £323.5 million.

As well as the huge PFI debt, South Tees NHS FT, along with the rest of the NHS has been struggling for years under a regime of underfunding.

The funding announcement in the Autumn budget in 2018 of £20.5 billion over five years, was very quickly shown to be insufficient.

The 3.4% rise in spending is significantly lower than the 4.3% annual growth in the Office for Budget Responsibility's projection of future cost pressures. This is an estimate that the IFS, think tanks and most economists agree is a fair measure of how much money the NHS needs just to keep up with demand, let alone improve standards.

The vast majority of hospital trusts, including South Tees, will also not benefit from the most recent announcement of money in August 2019.

This time an extra £1.8 billion in funding was promised but this was also very quickly shown to be all smoke and mirrors.

The vast majority of the money was not new at all, but money that had been promised to those NHS trusts by the Department of Health and Social Care (DHSC) after they cut their spending significantly.

However the promised reward for the spending cuts was not given to the trusts by the DHSC. The 'new' money is primarily a release of this 'reward' money and will only be given to 20 projects; South Tees NHS FT is not one of these projects.

Faltering promises to support cancer care are costing lives

PAUL EVANS

Now that half of us will get cancer at some point in our lives why can't we all have the best chance of beating it? Figures from Cancer Research UK this week illuminate how government inaction on NHS staffing is denying patients early access to diagnosis and treatment.

Every year around 115,000 cancer patients in England are diagnosed too late to have the best chance at survival, according to a fresh analysis from the cancer charity.

All the evidence points to the fact that catching cancer early provides a much better chance of successful treatment, but Cancer Research UK believe a lack of capacity is the biggest impediment.

Criticising the government's progress in increasing the NHS workforce in critical areas like diagnosis they highlighted that 1 in 10 of these posts are currently unfilled.

"There's no plan to increase the number of NHS staff to cope with demand now or the growing numbers in the future" says Emma Greenwood, Cancer Research UK's director of policy.

Bold promises

Last year the government pledged to catch 75% of stage 1 and 11 cancers by 2028.

That would mean a big step up in activity – with an extra 100,000 patients diagnosed early each year, but how realistic is this when currently cancer services are struggling to tread water.

Hospitals are continuing to miss their targets to start treatment quickly according to the latest NHS data for cancer waiting times. The current commitment is a maximum wait of 62 days from the time of referral by a GP, in fact nearly a quarter of patients wait longer

A dossier of evidence collected by the Hospital Consultants and Specialists Association (HCSA) confirms the problems with understaffing. A consultant radiologist reported that "Scan report turnaround time has gone from one week to over a month. Unexpected and critical findings are going unreported for weeks. We are now just firefighting."

The HCSA report that delays of five to six weeks for scans are common and patients are turning up to outpatient appointments but leaving without their results because scans are not available.

Despite a shortage of over 100,000 staff across the NHS and dire warnings that this is projected to rise to 250,000 by 2030 without the proper action, the government response has been painfully slow.

Despite a shortage of over 100,000 staff across the NHS and dire warnings that this is projected to rise to 250,000 by 2030, the government response has been painfully slow.

Only last year as the NHS celebrated its 70th birthday ministers pledged to catch 75% of stage 1 and 11 cancers by 2028

Missing plans

NHS England omitted any substantial workforce strategy from its 10-year plan for the NHS, launched in January.

When the plan finally arrived, it was an interim plan, widely welcomed for its intentions and analysis, but stymied by a lack of the essential funding that NHS leaders need to press on with training and recruitment.

Crucial treasury spending decisions were due this Autumn but have once again been delayed, probably until next year. The government is mired in political crisis and have lost all impetus on this crucial element in the NHS recovery. Meanwhile services are crying out for decisive support. NHS leaders, eyeing up another tough winter are left to struggle with growing demand, a flagging workforce and compromised services.

Just this week a BMA survey warned that nine in 10 doctors fear a 'toxic combination' of rising workload and understaffing will force them into making mistakes. The unified call being made from across the service is "give us more staff!"

The Government was told about severe staff shortages in NHS cancer care back In July 2015, according to the chair of the Independent Cancer Taskforce, Sir Harpal Kumar,

"It's totally unacceptable that these shortages could now lead to delays in patients getting treatment."

The Government defence is that they have already committed an extra £20.5 billion to the NHS over five years, but economists – including their own, have concluded that this investment is not enough to expand capacity and does not include the funding to train and hire new staff.

The Chancellor, Sajid Javid announced that the government will invest £250 million on new artificial intelligence technologies to help relieve the workload of doctors and nurses, but health experts remind us that

new technology would need time to become proven and this that would not fill the gaping hole in the workforce.

Capacity shortfall

Right now, staff shortages are affecting every part of cancer care according to work commissioned by Cancer Research UK. It is estimated that by 2027, the NHS needs:

- An additional 1,700 radiologists – people who report on imaging scans – increasing the total number to nearly 4,800
- To nearly triple its number of oncologists – doctors specialising in treating patients with cancer – a jump from 1,155 to 3,000
- Nearly 2,000 additional therapeutic radiographers – people who give radiotherapy to cancer patients – increasing the total to almost 4,800

The staffing crisis is double edged. There is not enough money to train the specialists of the future, but also many existing posts cannot be filled.

The Royal College of Radiologists says that one in six UK cancer centres now operates with fewer clinical oncology consultants than five years ago.

Vacancies for clinical oncology posts are now double what they were in 2013 – with more than half of vacant posts empty for a year or more.

Good and bad

Despite all the pressures, important progress has been made with improving services over the last 20 years. Cancer networks have adopted and shared the most effective techniques and survival rates have risen across many of the common cancers.

One in six UK cancer centres now operates with fewer clinical oncology consultants than five years ago. Vacancies for clinical oncology posts are now double what they were in 2013

However, the UK lags still behind other countries, performing worse than Australia, Canada, Denmark, Ireland, New Zealand and Norway, a study in Lancet Oncology found. Although based on data between 1995-2014 it backs up that case that the NHS needs a step-change in early treatment to catch up.

Sara Hyam who helped launch Cancer Research's campaign for more staff is confident that the problem does not lie in clinical approaches and believes the NHS has doctors and its treatments can match the best available anywhere in the world. The primary issue is that we are not treating patients early enough to give them the best chance at full recovery.

Shortages of staff are not the only factor: patients can be reluctant to acknowledge their symptoms and visit GP and in the past GPs have not always picked up on warning signs, but both of these factors are showing signs of improvement.

Broken promises cost lives

Healthcare is complex, but the keystone to building a service that can meet our needs is a resolute plan to put trained staff in the right posts to raise capacity.

Our government have been given this message loud and clear. Staff surveys, academic studies and the emotional experience of patients all echo the same themes.

Faith in politicians is at its lowest, but on the NHS and cancer specifically, they have lain out a string of powerful promises and asked to be judged on them.

With an election shortly upon us we will no doubt have to listen to more earnest pledges, but further inaction in the face of these basic health needs should rightly be regarded as a crime of neglect.

CCG mergers: efficiency drive, or something more sinister?

The NHS is caught up in more top down change. In over 20 areas the local bodies responsible for paying and organising our healthcare - Clinical Commissioning Groups (CCGs) are involved in a series of mergers, to form entities that cover much wider areas. The reasons behind the change are already causing controversy, not least because the public are in many cases being kept out of the process.

The two drivers of the CCG mergers are financial and the development of integrated care systems (ICS). They amount to a major NHS re-structure just a few years after its biggest shake-up to date in 2012.

In November 2018, NHS England wrote to all CCGs telling them they needed to make 20% efficiency savings to their running costs, placing "administration limits" on each.

NHS England have suggested that they save money by "exploring mergers and joint ways of working" - share back office and other functions and aim for savings on administration and a greater spend on patient care.

Casting doubt on the plan an HSJ analysis concluded that efficiency savings from mergers will not deliver the 20% reduction in running costs and in many situations may result in extra cuts.

Nationwide CCG mergers are designed to enable the government's new direction for the NHS – which is based around the development of Integrated Care Systems across England, as outlined in the NHS long-term plan announced in January 2019.

The plan states that England should be covered by ICSs by April 2021, and that an ICS should have just one CCG acting as commissioner across its area.

To speed up the merger process NHS England will now approve mergers throughout the year rather than just once a year.

The largest new CCG being planned will be formed by the merger of eight CCGs in North West London; this will cover 2.2 million people.

Political expediency plays a strong part in the merger plan as the government does not have a majority to get a new NHS reorganisation bill through Parliament.

Therefore, merging CCGs to the size of the bigger integrated Care Systems is a work-around solution to form a new structure out of the existing CCGs – who despite the emergence of ISCs will remain the body with the statutory responsibility for planning and funding local healthcare.

The Public Accounts Committee states: "We are … concerned about how patients will understand who makes decisions and keeps a close eye on the local NHS finances."

Why is it controversial?

Some commentators see this as u-turn away from the idea of local decision-making that was a strong theme within the 2012 NHS changes. They claim that forming super-CCGs will make health planning more remote from the populations they serve.

Local GPs who were cast as being in the driving seat of CCGs back in 2012 are now feeling distinctly left out, according to a Dr Richard Vautrey, chair of the BMA's GP committee.

"We have heard from members who are extremely alarmed that mergers appear to be rapidly moving forward in their areas without clear approval from, or sufficient engagement with, local GPs," he said.

Threat to planning

In early 2019, the Public Accounts Committee (PAC), commenting on the move to commissioning of services by ICS across much larger areas, noted:

"There is a risk that CCGs will lose touch with the needs of their local populations as they commission services across larger populations. It is vital that CCGs, in whatever form, understand the needs of their local populations and have good links with local GPs. But as CCGs become responsible for commissioning services across larger populations there will be a tension between commissioning at a larger scale while maintaining an understanding of the health needs of local populations."

A November 2018 report from the National Audit Office on CCGs also noted that the mergers seem to go against one of the original aims of the CCGs, that of commissioning services appropriate to the needs of patients in the local area:

"This larger scale is intended to help with planning, integrating services and consolidating CCGs' leadership capability. However, there is a risk that commissioning across a larger population will make it more difficult for CCGs to design local health services that are responsive to patients' needs, one of the original objectives of CCGs."

Accountability

The Public Accounts Committee has also identified a loss of accountability for patients:

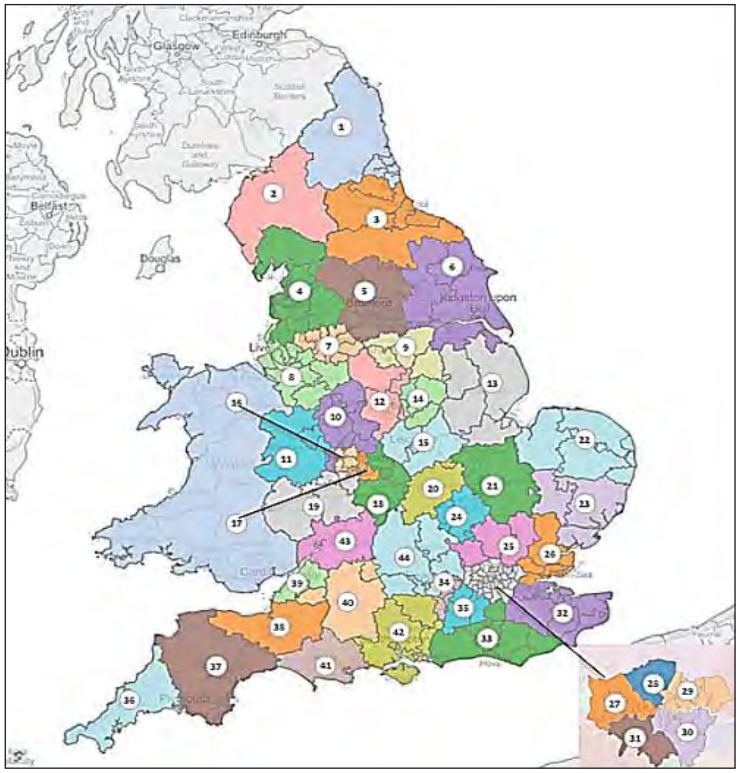
"We are also concerned about how patients will understand who makes decisions and keeps a close

Enforcing "tricky" decisions

One of the reasons behind mergers is to minimise any local voice or dissent while controversial closures and downgrades of hospitals and services are pushed through.

In Lancashire and South Cumbria, where 8 CCGs are planning a giant merger alongside the formation of an "integrated care system", the director of finance and investment has openly stated to the Health Service Journal that: "The place we need to get to is where we can enforce decisions on a majority basis." He wants to be able to push through "tricky" decisions that will be opposed locally.

Hospital "reconfiguration" is a key concern in Lancashire, with potential permanent loss of A&E and acute services in Chorley: eliminating any local voice will make that easier.



Top-down changes in 2016 carved England's NHS into 44 Sustainability & Transformation Plans. If CCG mergers continue to spread, the current 191 CCGs could be merged into as few as 40 by 2021.

eye on the local NHS finances."

At present the performance of individual CCGs is assessed by NHS England; PAC was concerned that as the ICS develop, accountability systems will be weakened as NHS England moves to assessing entire ICS rather than individual CCGs.

"it is important not to lose sight of the need for robust accountability structures which make it clear who is ultimately responsible for planning and commissioning decisions."

Existing flaws made worse

The accountability of commissioning and other key decisions has already come under sharp criticism and critics believe that these weaknesses will be exacerbated through mergers.

A catalogue of contracts have collapsed after CCG led tendering processes and local critics have called for these decisions to be more accountable and transparent.

Public consultations over aspects of local healthcare have been criticised for not offering meaningful involvement or for being side-stepped altogether. CCG decisions, especially around reconfigurations have often ended up facing local campaigns and have ended up being examined in the courts on multiple occasions.

Undermine the NHS

Other critics take the view that integrated care contracts will break down the central principle of the NHS to provide healthcare to all in our community.

The contracts may exclude or limit access to some healthcare and suggest a drift towards some of the characteristics of US-style accountable care.

After pressure from campaigners ministers have ruled out the possibility that private companies would be allowed to run an entire integrated care system under contract, but there is continuing concern about their influence and control.

In Thurrock, the local council criticised NHS England's "dreadful" proposals to merge the five CCGs in south and mid-Essex

A briefing by Keep Our NHS Public raises concerns about how Accountable Care Organisations will cement the decay of public funding of the NHS and help to strip NHS assets, such as land and buildings.

Public campaigns

Campaign groups across the country, such as South Warwickshire Keep our NHS Public and Save Southend NHS , are concerned that the merger decisions have been made to save money alone and will lead to services not being targeted at a local level.

The groups have also criticised a lack of consultation and about a future lack of transparency.

In Thurrock, the local council criticised NHS England's "dreadful" proposals to merge the five clinical commissioning groups (CCGs) in south and mid-Essex. Thurrock Council fears the loss of local accountability and strong existing partnerships and that a more centralised approach, could mean the different needs of patients and local priorities in the five areas would not be fully taken into account.

There are also concerns that GPs already do not have sufficient input into CCG decisions, and this will only get worse as the size of the CCG increases.

The Public Accounts Committee heard that a study by the King's Fund and the Nuffield Trust found only 28% of GP practices feel they can influence the decisions of CCGs.

Have local people been consulted on the proposals?

The mergers cannot take place without approval from the members of the CCGs.

There is some confusion, however, over how much consultation with the public is needed.

In many areas consultations have not taken place, but areas that have consulted include Birmingham and Solihull, Wyre Forest, Bradford and District, and Nottinghamshire/Nottingham. The public consultation in Birmingham for a merger that took place in 2018 was criticised by HealthWatch Solihull, as people felt they "did not have all the facts to allow them to make an informed decision."

As reported in the Lowdown last week Lewisham Hospital campaigners are demanding that there be full public consultation on CCG merger plans – and they believe they have the law on their side.

The campaigners have gone back to the amended NHS Act 2006 which (14G) stipulates that CCG mergers involve both the dissolution of the pre-existing CCGs and the formation of a new CCG.

And they have found that according to the Regulations governing the implementation of the Act, dissolution of a CCG requires the CCG to seek the views of all the people in the CCG area.

What are Integrated Care Systems?

Integrated care is an attempt get organisations working together to meet the health needs of their local population.

Integrated Care Systems are part of new policy to redesign the NHS through the creation of a partnership of organisations to plan and deliver care; involving NHS providers, commissioners, local authorities, third sector and for-profit companies.

In some areas ICSs will develop a single contract and one organisation will be take the lead and be responsible for its delivery under a fixed budget and by subcontracting the delivery of care to range of NHS, charity and private providers.

Campaigners have objected to the new scope for privatisation, and the lack of public accountability of ICSs which have no legal standing under the current NHS legislation.

No Deal Brexit: How bad can it be?

Hannah Flynn

The level of disruption that could be caused for the NHS by a no-deal Brexit was thrown into the spotlight last month when details from the Government's Operation Yellowhammer were leaked.

The Government has now been forced to publish the documents in full by Parliament, and the Scottish Parliament has already published its own no deal briefing highlighting healthcare as one of 12 most at risk areas. Most worryingly, the now officially published documents confirm the risk of medicines shortages, along with at least three months of shortages of food and fuel as border crossing points struggle to deal with checks. Operation Yellowhammer also assumes the eventual return of a hard border between the Republic and Northern Ireland.

Despite losing his majority and control of Parliament, Prime Minister Boris Johnson has continued to repeat his pledge that the UK will leave the European Union on 31 October 2019, whether a deal has been agreed with the EU or not. So what challenges will the NHS have to deal with in the face of a no deal Brexit?

Medicines supply shortages

A recent media storm surrounded an on-air argument between Jacob Rees-Mogg MP and Dr David Nicholl, who had advised the Government on the risks of leaving the EU without a deal on patients and their medicine supply.

Rees-Mogg suggested Nicholl was irresponsible for vocalising "the worst excess of Project Fear", despite leaked Operation Yellowhammer documents warning delays at channel crossings would make medicines "particularly vulnerable to severe extended delays" "with significant disruption lasting up to six months" if unmitigated. These could impact as much as 40-60 per cent of imports from day one.

Medicines and medical supplies that required specific transport conditions, such as temperature controlled environments like insulin, or had short shelf-lives such as medical radio isotopes, would be particularly hard-hit, the documents warned. Heads of health bodies including the RCN, RCM and BMA warned at the end of August that agents necessary for cancer diagnosis and treatment were at risk in a no-deal scenario.

It is unclear what the impact of tariffs would be on exports, and it is hoped the World Trade Organisation (WTO) would agree to a WTO Pharmaceutical Tariff Elimination Agreement in the case of the UK leaving the EU without a deal. The cost of any tariffs would almost entirely be borne by the NHS.

The pro Leave Institute of Economic Affairs (IEA) believe that tariffs would affect a limited number of pharma ingredients and devices but acknowledge that the NHS would have to absorb a rise in prices on some products.

Royal Pharmaceutical Society Director of Pharmacy and Member Experience Robbie Turner said it was important to remember that global supply chain issues for medicines had been an issue for years, and "we will continue to see shortages for years to come and no deal Brexit could make that worse, but we have no indication that the global supply chain issues will be altered by Brexit."

45 per cent of doctors from the EU stated they were considering leaving the country and one fifth had made plans to leave.

Staff shortages

There are already 100,000 vacancies in the NHS, a situation that is set to worsen in or out of the EU due to increased demands on our health services. The Kings Fund has calculated that the UK needs to recruit at least 5,000 new nurses each year from abroad to simply stop the situation worsening.

There are 116,000 EU nationals working in health care, meaning that any impact on them has the potential to significantly impact the health service, a joint letter by The Kings Fund, the Health Foundation and Nuffield Trust has warned. A BMA survey found that 45 per cent of doctors from the EU stated they were considering leaving the country and one fifth had made plans to leave.

If a no deal Brexit caused a significant drop in the pound, then many NHS staff could leave if it makes working in the UK no longer a competitive option, The Kings Fund has also warned.

The reintroduction of a hard border between Northern Ireland and the Republic of Ireland could also cause a disproportionate impact locally due to a high vacancy rate in Northern Ireland, as NHS staff who reside in the Republic could struggle to get into work.

This would be exacerbated by Home Secretary Priti Patel's plans to remove freedom of movement for EU nationals on 31 October.

Economy

The Budget for Office Responsibility has claimed that a no deal scenario would likely require an extra £30 billion of borrowing each year.

This is more money than was spent on adult social care and investment in NHS buildings and equipment in 2017/18 alone according to The Kings Fund.

Economically problematic is also the precarious nature of many of the companies that are now responsible for outsourced health and social care. Operation Yellowhammer documents warned:

"An increase in inflation after the UK's EU exit would affect providers of adult social care through increasing staff and supply costs, with smaller providers impacted within 2-3 months and larger providers 4-6 months after exit."

Guy Collis, a Policy Officer at UNISON explains how this might have an impact on the NHS:

"So many companies in social care are already in a very unstable financial position, and if there is the expected shock on the wider economy then numbers of providers could be exiting the sector or going bankrupt, and the likelihood is then there will be a fairly major knock on impact on the NHS."

"Though it is unclear what emergency support the NHS would be expected to provide, care homes going bust could see an increase in demand on A&E and community services which are already under significant pressure.

"Even if there was no Brexit whatsoever we would still see a number of care providers going under like Southern Cross a few years back.

"The problem is the services and staff usually transfer to another operator, but if they are all experiencing problems [following a no deal Brexit] then it is not clear how easy that would be," Collis warns.

The impact of leaving the EU without a deal on fuel and food availability could also affect the NHS practically and financially.

Rising costs and shortages

Looking outside of the health and social care system, it is also likely that the impact of leaving the EU without a deal on fuel and food availability could also affect the NHS practically and financially.

Even if "everyone will have the food they need" as promised by Michael Gove, increases in the cost of food and fuel could further squeeze NHS budgets. If the UK leaves the EU with no deal then it will be subject to World Trade Organisation tariffs on food and other products, such as a 35 per cent tariff on dairy. Skyrocketing hospital food bills aren't going to help anyone.

Speaking at an Exiting the EU Select Committee hearing, Andrew Opie the British Retail Consortium director of food and sustainability said: "I think there's been too little debate around the three, six, nine-month period [after Brexit],"

"For us, for example, we will [initially] have a temporary tariff on food, but how long will that temporary tariff last?", reported Civil Service World. He also warned that late October would be the worst possible time for the UK to face a no deal Brexit as its fresh food import needs peak over the winter.

Dave Prentis warned ahead of the Trades Union Congress in Brighton this week that: "the catalogue of logistical nightmares goes on. The NHS serves more than 140 million meals to patients every year, with much of the food imported from Europe.

"Possible fuel shortages could have a severe impact on 6,500 emergency ambulances and their crews operating countrywide, especially those in areas with lorries queuing out of the ports."

While it is not expected that the World Trade Organisation would implement tariffs for gas and electricity in the case of a no deal Brexit, industry experts do expect costs to rise, Bloomberg reported earlier this year.

NHS chronic underfunding has left it with a £991 million combined deficit according to the National Audit Office, making it unclear where any money will come from to pay for these rising costs of running NHS services.

While it would be incorrect to blame all of the NHS's problems on a no deal Brexit, it is certainly the case that leaving the EU without a deal will significantly exacerbate a wide range of problems already afflicting our underfunded services.

THE lowdown

Health news, analysis and campaigns.
NUMBER 10, Sept 28 2019

Informing, alerting and empowering NHS staff and campaigners

£200m for scanners

As we publish this issue (28 Sept) Prime Minister Johnson is set to announce a £200 million cash injection to replace MRI machines, CT scanners and breast screening equipment.

Of European countries only Hungary has fewer MRI and CT scanners per head than the UK. Delays are growing and targets are being missed in the treatment of cancer.

The Health Foundation estimates much more (£1.5bn) would be needed to bring the UK up to EU average provision.

The funding that has now been promised is expected to provide 300 diagnostic machines in hospitals across England, although the ancillary costs of modifying or extending buildings and facilities are not covered.

Johnson's promise received a critical response from Cancer Research UK, which told ITV News that the machines themselves are not enough: staffing shortages in the NHS need rectifying as a priority. **"These new machines will only work if there is staff to operate them."**

Shadow health secretary Jonathan Ashworth said Mr Hancock was "yet again following our lead" with the announcement. The Department of Health said the machines, to go to more than 80 trusts, will improve efficiency and improve patient safety by delivering lower radiation levels.

Meanwhile NHS England has been seeking to push through plans that fragment and privatise the provision of specialist PET-CT scanning services in Oxfordshire and elsewhere.

Labour backs call to scrap NHS charges

In what seems certain to be the last Labour conference before a further general election, decisions were made to call on a future Labour government to scrap charges that stand as an obstacle to people accessing the NHS treatment they need.

A wide-ranging composite motion called for repeal of sections 38 and 39 of the 2014 Immigration Act and subsequent regulations which enforce up front charges of 150% of the cost of treatment on people who cannot prove they are normally resident in the UK.

Shadow Health Secretary Jonathan Ashworth had earlier lent his support to this proposal at a conference fringe meeting and it's likely to survive Diane Abbott's subsequent statement that Labour will not take on all of the points of the immigration motion.

Nye Bevan, founder of the NHS insisted that services should be free to all, and rejected calls to charge "foreigners," arguing it would raise little money but require everyone to prove identity. Theresa May's racist "hostile environment" policies scrapped this principle, and NHS trusts are now required by law to check patients are entitled to free care.

Save Lewisham Hospital Campaign discovered that 18% of 9,000 women who gave birth in 2017/18 in Lewisham and Greenwich hospitals were challenged to prove their entitlement to NHS treatment, and 541 were charged £6,000-£9,000 for their care.

Nye Bevan rejected calls to charge "foreigners" arguing it would raise little money but require everyone to prove identity

Now the Royal College of Midwives has demanded these charges be suspended until it can be proved they are not harming women.

BMA vice chair David Wrigley has also warned that doctors will not assist the imposition of a "hostile environment": "It is a doctor's job to treat the patient in front of them, not determine how the treatment is being paid for."

People fighting to scrap the charges will of course have to combat the right wing media and their false and malicious claims on the costs of "health tourism".

■ An additional positive step forward was Jonathan Ashworth's speech committing Labour to scrap NHS prescription charges, which currently only apply to ten percent of prescriptions in England – while Wales, Scotland and Northern Ireland have already abolished them.

Citing the tragic example of 19-year old Holly Warboys who died because she couldn't afford an inhaler, Ashworth said:

"People shouldn't have to pay to breathe. Prescription charges are a tax on illness. I can confirm the next Labour government will abolish all prescription charges."

IN THIS ISSUE

NHS England calls for new legislation to scrap compulsory tendering

John Lister

While Prime Minister Johnson seeks pre-election voter popularity by reeling off a series of promises of "extra" funding that falls short of reversing the real-terms funding freeze that has squeezed the NHS for the past nine years, NHS England has drawn up a shopping list of reforms it wants pushed through Parliament in new legislation.

The Guardian report flagging these up is optimistically headed "NHS privatisation to be reined in under secret plan to reform care."

It states that the proposals, drawn up by NHS England and NHS Improvement after protracted engagement with various organisations and individuals, are expected to feature in the Queen's speech next month.

The most substantial proposals centre on repealing section 75 of the 2012 Health & Social Care Act and the sections establishing the Competition and Markets Authority's (CMA) roles in the NHS, and going further to remove the commissioning of NHS healthcare services from the jurisdiction of Public Contract Regulations 2015, and abolish Monitor's specific focus and functions in relation to enforcing competition law.

End compulsion to tender

Between them these changes would remove the compulsion to put NHS healthcare services over £615,000 a year out to competitive tender. As such this proposal has been welcomed by UNISON's Head of Health Sara Gorton, who said:

"This is long overdue. These proposals would protect the NHS from the worst excesses of privatisation and end the situation where different parts of the health service have had to compete against each other."

UNISON has joined with 17 other organisations including NHS Providers and the Local Government Association in signing a letter calling for a Bill to be included in the Queen's Speech, which "should be tightly focused on the issue of care integration to foster collaboration within the sector, including removal of section 75 of the 2012 [Health and Social Care] Act with its unnecessary procurement processes."

The proposals set out by NHS England and NHS Improvement would not reverse any of the privatisation that has already taken place, or prevent NHS England, CCGs or NHS trusts from choosing to put further services out to tender

But while they are welcome as far as they go, the proposals on Section 75 and competition set out by NHS England and NHS Improvement are for many seen as a starting point rather than a satisfactory conclusion.

They would not reverse any of the privatisation that has already taken place, or prevent commissioners, NHS England or NHS trusts from choosing to put further services out to tender.

Not far enough

The proposals certainly don't go as far as Shadow Health Secretary Jonathan Ashworth feels is necessary. Ashworth led the unsuccessful opposition in Parliament to regulations laying the basis for Integrated Care Partnership contracts, and he is concerned now about the limitations and implications of the rest of the proposed Bill, which heads along similar lines.

He told the HSJ:

"We want to see the Lansley Act repealed, we want to restore a public universal NHS. We want to end fragmentation, to see care delivered on the basis of planning, not on the basis of markets and competition."

The GMB union, which has also campaigned for the removal of Section 75 and its regulations, also argues that the new Bill does not go far enough.

Other proposals put forward by NHS England include:

- Some apparent concessions on local accountability in an attempt to win wider acceoptance of new Integrated Care Systems – even though these would be functioning outside the existing legislation:

"NHS England and NHS Improvement should develop statutory guidance on governance of ICS joint committees. To increase transparency, ICS joint committees should not only meet in public, as recommended by the Select Committee, but also hold an annual general meeting, and publish an annual report. Their decisions would also be subject to scrutiny by Local Authority Overview and Scrutiny Committees."

- Tariff changes and a new procurement regime to "guard against the risk of introducing competition solely on price as opposed to quality."
- A new 'triple aim' for NHS commissioners and providers alike, of "better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer."
- Allowing NHS commissioners and providers to form joint decision-making committees on a voluntary basis, "rather than the alternative of creating ICS as new statutory bodies, which would necessitate a major NHS reorganisation."
- Local authorities should be able "actively encouraged to join ICS joint committees" with full membership – as long as they do not interfere on decisions over cutbacks and closures ("not introducing a new local government veto over the NHS's discharge of its own financial duties")

● Changing the 2012 Act to support the creation of integrated care providers as NHS trusts, and to ensure that "only statutory NHS providers should be permitted to hold NHS Integrated Care Provider contracts."

A number of NHS England's initial proposal have now been dropped, most notably "NHS Improvement's proposed power to direct mergers between Foundation Trusts", which was rejected by the Select Committee, NHS Providers and the NHS Confederation, and "not supported by the NHS Assembly".

It's a mixed bag, in which only the retreat from further privatisation is explicit. Campaigners would be critical of many of the other proposals.

Whether the Bill even appears in the Queen's Speech, and whether it might be passed through the Commons, given the government's lack of a majority and the quite deliberate stoking up of opposition anger as Johnson has tried to force an early election that could enable him to push through a no-deal Brexit on October 31, is an unanswered question.

No chance in Commons

Jonathan Ashworth has argued that the government "has got no chance" of getting the NHS Integration Bill through Parliament: "I'm not convinced [health secretary] Matt Hancock will go as far as what is needed to provide the care that patients deserve. The Conservatives have lost their majority and, as things stand, I think Mr Hancock has got no chance of getting any legislation through at the moment."

The invitation to NHS England to take the lead in formulating the scope of legislation to deal with the fragmentation and contracting out of services entrenched by Andrew Lansley's 2012 Health and Social Care Act first came from Theresa May in the summer of 2018. Outline proposals were included in the NHS Long Term Plan published back in January.

But since then many aspects of the situation, and most of the cabinet have changed: last November Health Secretary Matt Hancock made clear the government would only proceed if Labour would effectively sign off on the NHS England proposals without amendment or addition:

"Crucially… if we bring this bill forward and people add things to it that don't work, or cost too much money, or are going to cause us problems, then we may have to drop the bill altogether. And it will be the people bringing forward additional baubles whose fault that would be, not mine."

It seems that the NHS Integration Bill, like so many other policies in these uncertain times, is far from a done deal, and certainly not the far-reaching package of legal changes most campaigners want to see.

Unlike most of Johnson's announcements, which have aimed to lure voters with the dubious promise of extra cash, these legal changes will be understood by few people, and are unlikely to grab the attention or support of many voters.

That's why, even if he does get the nod to push it forward, Hancock is clearly preparing to duck and run if he can't get the support he wants, and faces too many awkward questions.

Duty-free promise to distract us all from no-deal worries

Ministers are now publishing correspondence with the EU negotiators that reveals the extent of their gross failure to prepare for the disastrous no-deal outcome they have been relentlessly steering towards since Johnson took office as PM.

But relax: according to the Chancellor, however appalling the situation after Britain crashes out with only WTO rules to trade upon, those of us who can still afford to travel to the EU will be able to take comfort in the old-fashioned pleasure of … duty free booze and fags.

A government press release on September 10 headlined "Chancellor announces return of duty-free," and enthused:

"Passengers travelling to EU countries will be able to buy beer, spirits, wine and tobacco without duty being applied in the UK, **thanks to the lifting of EU rules."**

"For example, a holidaymaker could save more than £12 on two crates of beer. The travel industry has been calling on the government to re-introduce duty-free, **which stopped when the EU Single Market was introduced**."

The prospect of Brits drowning their sorrows with large quantities of duty-free drink and puffing their way through bulk buys of tobacco will no doubt add to the concerns of public health experts, who were already warning that a no-deal Brexit is a threat to public health.

A letter to the Guardian signed by 29 leaders in public health warns that:

"Brexit is proceeding at a time when the long-term improvement in life expectancy has slowed and, for some age groups, gone into reverse, while the most vulnerable in our population face growing insecurity of income, employment and even food.

"We believe that all of these would be exacerbated by a no-deal Brexit."

The health threat from a no-deal comes in addition to the growing problems of social inequality that are driving a deepening of health inequalities: the latest analysis shows a massive 16 year difference in healthy life expectancy between different areas of Britain – as wide as the gap in life expectancy between Britain and Sudan.

The people with the fewest average years in good health were in Blaenau Gwent in South Wales, with just 54.3 years: the highest healthy life expectancy in Britain is in leafy Wokingham, at 70.7 years: the national average is 63.6 years.

No medicines or food? No worries with cheap booze & fags!

Now it's official: CCG mergers aim to drive through "majority" plans

CCGs don't offer much resistance now, but management hope merging them, and creating "Integrated Care Systems" can speed through controversial changes with less opposition

As we have discussed in previous issues of The Lowdown, the controversial process of merging Clinical Commissioning Groups is well under way. John Lister gives an update.

If NHS England gets its way the days of any local accountability of Clinical Commissioning Groups (CCGs) could be numbered: according to an HSJ report NHS England is stepping up the pressure for groups of CCGs to merge: the latest proposals could see the current 191 CCGs in England reduced to just 40.

However one planned merger – of the six CCGs in **Staffordshire** – has now been formally scrapped after a majority of GPs in five of the CCGs voted to reject the idea. The merger plan had already been criticised as a "cost-cutting exercise" which had no benefits for patients by the Alcott, leader of Cannock Chase Council.

The GPs were told the plans were "driven by NHS England", by Dr Paul Scott, chair of the North Staffordshire Local Medical Committee, who advised his members to reject the merger. He wrote in an email, seen by HSJ:

"Much has been made of the potential benefits of having a single CCG in Staffordshire, yet few if any of these arguments hold true or are at best speculative."

Minimise local voice

Campaigners have argued that one of the reasons behind this drive to merge CCGs into such large units is to minimise any local voice or dissent while controversial closures and downgrades of hospitals and services are pushed through.

Now there are explicit statements from senior NHS management that confirm this is the case.

In **Lancashire and South Cumbria**, where 8 CCGs are planning a giant merger alongside the formation of an "integrated care system", the director of finance and investment has openly stated to the Health Service Journal that he wants to be able to push through "tricky" decisions: "The place we need to get to is where we can enforce decisions on a majority basis."

Hospital "reconfiguration" is a key concern in Lancashire, with potential permanent loss of A&E and acute services in Chorley: eliminating any local voice will make that easier.

Councils of various political complexions in London and elsewhere have warned of the impending loss of accountability: in **Essex,** where there are plans to merge 5 CCGs, the Conservative Leader of Thurrock Council, Cllr Rob Gledhill said:

"We understand the need for the NHS and all public sector bodies to work as efficiently as possible, but that should not be to the detriment of residents who rely on the vital services our local CCGs are involved in providing.

"Creating a single CCG responsible for commissioning health services for 1.2milllion people across south and mid Essex would not only be a huge challenge because of the sheer size of the area, but would result in the loss of local accountability and would be a real waste of the excellent local partnerships that have been formed.

"By taking a more centralised approach, we also fear that the different needs of patients and local priorities in the 5 areas would not be fully taken into account. We would strongly urge NHS England to think again about these dreadful proposals to avoid irreparable damage to a health service we are all very proud of."

Council health and scrutiny committees, which still retain powers which date back to the 1970s to delay and challenge changes in services, may become the last vestige of local account-ability in an "integrated" NHS

Telford says No

In **Shropshire**, Shaun Davies the Labour leader of Telford & Wrekin council, which has been fighting against the 'Future Fit' plan to downgrade the local hospital and move services to Shrewsbury, has also come out firmly against a merger of CCGs: he warns that any merger between the two CCGs would see health funding and resources being diverted out of the borough to Shropshire.

Telford and Wrekin's CCG has a balanced budget while Shropshire CCG has had a mounting budget deficit, currently at around £28 million. Cllr Davies said:

"This is simply Telford and Wrekin being fleeced to sort out Shropshire's financial problems and years of poor management. This feels like the whole 'Future Fit' debacle again - Shropshire takes over, Telford and Wrekin loses out, robbed to pay off Shropshire's debt."

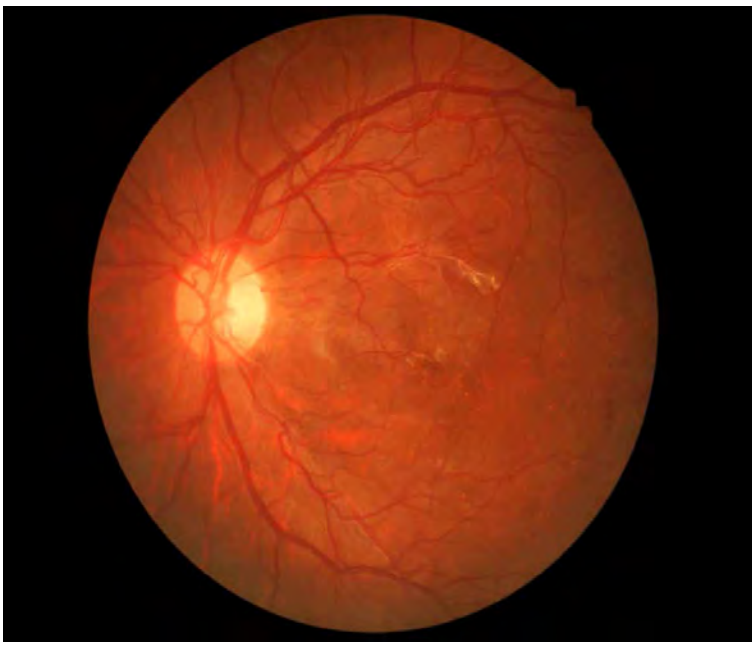
In **North West London**, where another 8 CCGs are set to merge into the biggest CCG covering 2.2 million people, NHS bosses are still smarting from the collapse of their 7-year effort to force through hospital closures affecting two boroughs, Hammersmith & Fulham and Ealing: a merged CCG would be even more remote from local campaigners.

That's no doubt why, despite regulations requiring them to do so, few if any of the planned mergers involving 86 CCGs have involved any genuine public consultation, or taken any real notice of the views of local councils which in theory should be regarded as partners.

The mergers are another top-down bureaucratic reorganisation.

If NHS England brazens it out and pushes through these mergers, council health and scrutiny committees, which still retain powers which date back to the 1970s to delay and challenge changes in services, may become the last vestige of local accountability in an increasingly centralised and monolithic "integrated" NHS.

Manchester campaigners' eyes are on private takeover of screening service



You need a GCSE to do this stuff

On April 1 diabetic eye screening services for all of Greater Manchester were moved from NHS hospitals and opticians to the private company Health Intelligence (HI), which describes itself as

"a leading software provider of information management solutions for health organisations in the UK. Our main areas of focus are on Diabetic Eye Screening services and population based data analysis to improve Long Term Conditions diagnosis, promote prevention and identify cost savings."

Subsidiary

HI is a subsidiary of InHealth, the provider of managed diagnostic services and healthcare solutions to the NHS, which has been embroiled for months in a row over a contract to deliver PET-CT scanning services in Oxfordshire, Swindon and Milton Keynes.

The privatisation was not the result of any failures by the NHS: patients were told "Health Intelligence, the new provider, will continue the excellent service you used to receive."

Instead of investing more in hospital services, NHS England last year commissioned two 5-year contracts for diabetic eye services (the combined contract was tendered with an estimated value of £27m).

Because each part was worth over £615,000 they had to be put out to tender: and HI won.

Previously these services were centred in-hospital at Salford Royal and Central Manchester, and at high street opticians. Now they will all be centred at HI's chosen facilities.

Access to consultants

In hospitals screeners have access to consultants for advice on the grading and interpreting of images of retinopathy. Now some of the staff formerly employed by the NHS have been taken on by HI, but without the access to a consultant.

In Greater Manchester, no high street optometrists are being employed for screening and hospital screeners who were previously employed by the NHS are now employed by HI.

It is not clear whether other HI staff will have been trained to NHS-equivalent standards.

In London in 2016 their diabetic screening was carried out by 10 local optometrists, clinical leadership was sub-contracted to a private consultant, slit lamp biomicroscopy was provided by another private provider, and results were graded by six private sector individuals.

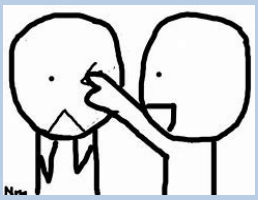
The company has a number of advertisements for retinal screener/graders, 'working unsupervised', with senior retinal screeners helping monitor the retinal screeners together with Team Leaders.

A poke in the eye

Everywhere in Greater Manchester: diabetic eye screening run for profit

Bolton cataract eye surgery: run for profit

Reverse privatisation of NHS eye services in Greater Manchester!



GCSE required

The salary is £18,500 and requires candidates to be educated to GCSE level and they must complete the Diploma in diabetic retinopathy screening.

Since 2011 HI have previously taken over diabetic eye screening in at least 9 counties (Suffolk; Essex; Middlesex; Kent; Hampshire, Dorset, Berkshire, Somerset, Devon and Cornwall).

Before if you went to a high street optician, they have been extensively trained in screening for diabetes which often has not been previously diagnosed. Now in Greater Manchester they can no longer screen you, but will have to refer you to back to your GP who will then refer you to HI.

After High street and hospital staff told campaigners that they are worried about patient safety under the new arrangements the campaigners are now calling on Greater Manchester Mayor Andy Burnham to join them in demanding that local health commissioners (the Greater Manchester Health & Social Care Partnership) end the contract with HI and bring this service back in house.

Campaigners are calling on Greater Manchester Mayor Andy Burnham to join them in demanding health chiefs bring the service back in house.

In Bolton...

Cataract eye surgery has been privatised to the for-profit company Spa Medica, which has contracts elsewhere and is connected to SSP Health Ltd which manages 37 GP practices across the North West.

Up to 98% of patients in Bolton are using Spa Medica, but several have told us that they weren't offered any choice of using the hospital, but were sent direct to the private company.

Some diabetic eye screening is now being done at SSP Health's Bolton office.

The campaign can be contacted via ***https://keepournhspublicgmcr.com/***

THE lowdown

Health news, analysis and campaigns.
NUMBER 11, October 12 2019

Informing, alerting and empowering NHS staff and campaigners

RCP warns of vacancies

THE rate of unfilled NHS consultant psychiatrist posts has doubled in the last six years in England, according to a survey by the Royal College of Psychiatrists.

One in 10 posts are vacant, up from one in 20 in 2013.

Vacancy rates are particularly high in areas of mental health care prioritised by the Government for improvement, prompting fears that plans to transform services over the next 10 years under a major investment programme will fail.

They are also higher in some regions: in eating disorders, the vacancy rate for consultant psychiatric posts is 11% in the East Midlands (Trent), but soars to 17% in the South East and South West and 33% in the East of England.

Although access to children's mental health services in England is improving, only 35% of those who need it get treatment.

Earlier this year, a report published by the College found that people with eating disorders can wait up to 41 months for treatment, with adults waiting on average 30% longer than under-18s.

■ A successful **Mental Health Summit** on September 28 organised by campaigners including Keep Our NHS Public and Health Campaigns Together has now published video and reports as part of a drive for more concerted campaigning.

Private GP service sets sights on further NHS expansion

Paul Evans

Babylon health plans to expand its virtual GP service to Manchester after its reported success in attracting NHS patients to use its GP at Hand business.

The private company, which offers fast GP appointments by video has attracted over 60,000 NHS patients in Birmingham and London and if its plan is accepted will be up and running in Manchester by early 2020.

Despite its potential expansion to three major cities, under current regulations patients who sign-up for GP at Hand are all registered with Babylon Health's GP practice in Hammersmith & Fulham in West London; so it's this CCG that will be required to give approval for the expansion to Manchester.

Problems for CCG

Babylon's expansion in this way has led to major financial problems for Hammersmith and Fulham CCG as it is responsible for thousands of new patients registered on GP at Hand whether they live in their area or not.

The CCG eventually gave approval for the expansion to Birmingham, with the proviso that no more than 2,600 patients be registered in the area in the first three months.

However, changes announced in late September by NHS England and NHS Improvement will change this and have a significant effect on the way Babylon Health operates from April 2020 onwards when they come into force.

The app will see you now …

New contracts for 'digital-first' GP providers will probably require them to set up a physical clinic in the area

The new rules cover out-of-patient registration and mean that once 1,000 patients are registered in a CCG area by a provider outside this area, then the provider will be issued with a new APMS contract covering that area.

Financial burden

This means the patient list is divided up and no single CCG bears the financial burden of thousands of extra out-of-area patients.

GP at Hand has approximately 60,000 patients living outside Hammersmith and Fulham, and these patients will now have to be divided into 17 different lists in areas where GP at Hand has more than 1,000 patients.

Other changes mean that in the areas where the new contracts are issued to the digital-first GP providers they will probably be required to set up a physical clinic in the area.

There is also a proposal that new digital primary care providers should be required to set up in areas lacking doctors and primary care access is poor.

Figures obtained by *GPonline* suggest that more than one in four NHS patients who registered with Babylon GP at Hand quit the video consultation service within just over a year.

IN THIS ISSUE

Watchdog finds another care home company in trouble

Sylvia Davidson

The care home company Advinia is under investigation by the Care Quality Commission (CQC) following concerns that the company is financially unstable, according to a report in *The Guardian*.

Documents leaked to the Guardian show that the CQC is concerned about the cash flow at the company and its ability to pay its debts.

In late August, the CQC warned over 150 local authorities in England and Scotland that Advinia was not cooperating in a financial investigation and the CQC could not give the company a clean bill of financial health. The local authorities now have to decide whether to use the company as a provider or not.

Advinia's 38 care homes look after around 3,000 elderly residents and employ 4,500 staff in England and Scotland. In April 2018, the company acquired 22 homes from BUPA and as a result became the 10th largest company in this sector in England.

The *Guardian* understands from the leaked documents that Advinia has been blocking the CQC from conducting an independent business review of its finances; the CQC has the legal powers to scrutinise a provider's accounts if it "considers that there is a significant risk to financial sustainability". If Advinia does not comply with the CQC request the company could lose its licence to operate.

The documents seen by the Guardian also show that the CQC was worried about the "competency and capabilities" of Advinia's finance department; the company has had four finance directors over five months of the summer.

The leaked documents say that Advinia has sent a letter to the CQC setting out its reasons for not cooperating, but the regulator insisted this did not provide "the necessary reassurance".

Inadequate

The CQC has also had concerns over several of the company's care homes in recent months. In October 2018, the Arncliffe Court home in Liverpool received a damning CQC report with a rating of 'inadequate, then in early 2019 the Burrswood care home in Bury and Barrock Court home, just outside Carlisle, both received bad reports.

Burrswood had fallen from 'good' prior to its acquisition from BUPA to 'requires improvement', whilst the Barrock Court home requires improvements in all areas. The CQC inspection of Barrock Court was prompted by concerns from health professionals.

Advinia was set up by Sanjeev Kanoria and his wife Sangita 20 years ago. Kanoria has numerous business interests globally, including the ownership of the Austrian Anadi Bank, which he acquired in 2013.

There have been concerns about the financial vulnerability of the care sector for many years.

The sector has suffered from austerity measures instigated in 2010 when government reductions in local government funding led all local authorities to cope with the funding crisis by reducing the fees paid to care providers in both the residential and the home care sector. Many companies in the residential care sector, in an effort to increase their profits, have resorted to complicated business models backed by private equity and are now reliant on risky financial structures.

This leaves them exposed to collapse, with damaging consequences for care home residents.

In 2011 this is what happened to Southern Cross, a large national care home provider which had 9% of the market nationally. The company's collapse risked the care of 37,000 people.

Other private companies took over the Southern Cross contracts, primarily Four Seasons. But by the end of 2017, Four Seasons, itself was on the brink of financial downfall. The uncertainty around the company was only relieved when it struck a deal with US private equity investors and deferred debt payment. In April 2019, however the company went into administration.

The debt that eventually brought down Four Seasons was estimated to be £500 million.

In November 2016, a report by OPUS found more than one in four care homes across the UK will be facing a financial crisis over the next three years; this means that more than 6,000 care homes could close if they are not rescued by a new owner.

In March 2019, accountancy firm BDO reported that more than 100 care home operators collapsed in 2018, taking the total over five years to more than 400. Its report warned that as homes closed many patients would have nowhere else to go but hospitals.

Financial instability is also a major problem in the home care market. In 2017, a report produced by the Local Government Unit think-tank and Mears, one of the leading home care providers, concluded that the home care business was on the brink of collapse; companies were either going bankrupt or pulling out of contracts.

More recently, in October 2018, the CQC took the unprecedented step of writing to 84 local authorities with concerns for the financial stability of Allied Healthcare and its ability to continue to provide home care services past 30 November 2018.

The CQC was concerned that Allied Healthcare would not be able to make a loan payment due at the end of November. The company was saved from going into administration by its sale to Health Care Resourcing Group for an undisclosed sum in December 2018.

For more details on the long-term care market see the overview on the NHS For Sale website.

In 2017, a report produced by the Local Government Unit think-tank and Mears, one of the leading home care providers, concluded that the home care business was on the brink of collapse

Hints of possible bursary U-Turn

There is a possibility that some type of financial incentive will be reintroduced to try and increase the number of people choosing to train as nurses, according to a report in the HSJ.

This would be a major U-turn for the government, which in 2015 removed the bursary system for trainee nurses. The removal of bursaries led to 10,000 fewer applicants in 2017, and nurse vacancies in the NHS have risen to over 40,000.

The Department of Health and Social Care is discussing with NHS England, Health Education England, and NHS Employers, which represents England's 240 NHS trusts, the possibility of bringing back cost of living grants of £3,000 to £5,000.

The financial inducements may also be expanded to other health professionals where there are major shortages, including paramedics and podiatrists.

The *HSJ* also notes that there has also been a suggestion that debts from doing a first degree could be written off.

Until bursaries were removed in 2015, nursing degrees attracted many mature students, who already had thousands of pounds worth of debt. Applications from mature students have now plummeted.

The target will be mature students and those specialising in mental health and learning disability nursing

If financial incentives are introduced, it is likely that that they will be restricted to certain groups, however.

The target will be mature students and those specialising in mental health and learning disability nursing; these two areas have major workforce shortages.

The idea has been welcomed by Chief Executive of the Royal College of Nursing, Dame Donna Kinnair, however she told The Guardian that it would take an injection of at least £1 billion a year into nursing education, through both tuition support and also help with living costs, to get back to the number of applications there were before 2015.

Lincolnshire health visitors' dispute escalates

More than 70 Lincolnshire health visitors are being balloted for strike action as the long running pay dispute escalates with county council bosses trying to 'divide and rule' over future job roles.

Unite said the new ballot would not only involve the health visitors who have been denied legitimate pay rises by the council since October 2017, but health visitors on the lower grade 9 and higher grade 10.

The ballot opens on Friday 11 October and closes on Friday 25 October.

They have already taken action on 32 days since July with the loss of around 450 shifts.

The dispute began over health visitors having lost more than £2,000 a year since they were transferred from the NHS, but Unite says it has now taken up the council's insistence on different contracts for grade 9 and grade 10 health visitors.

Unite argues that as all health visitors have the same community nurse qualifications, the same workplace training, and their role is equivalent to a grade 10 job role, and should therefore be graded and paid accordingly.

Unite regional officer Steve Syson said: "This dispute has now escalated due to the fact that the council has provocatively divided the health visitor role into two separate jobs.

Divide and rule

"This tawdry 'divide and rule' sleight-of-hand manoeuvre from this cash rich council, with a surplus of £188m for 2018/19, needs to be exposed.

"I hope all our members fully support this ballot, because, if they don't vote to take action, they will be accepting the division of the role and for those that don't move onto a grade 10 it will mean a loss of £4,000 per year, which is totally unacceptable."

Unite said that the county council's continual refusal to negotiate constructively since strike action originally commenced in the summer was having an adverse impact on Lincolnshire families with babies and young children.

"The council's blinkered action has already led to some of our very experienced members leaving their job to seek alternative employment where their qualifications are better respected and this drift will continue."

■ The strikers have launched a crowd-funding appeal to help alleviate hardship.

It's blue on blue conflict as Shropshire's MPs quarrel over Telford hospital downgrade

John Lister

Matt Hancock's decision to rubber-stamp highly contentious plans to downgrade Telford's Princess Royal Hospital, moving A&E and women and children's services to a new £312m hospital in Shrewsbury has brought the spectacle of local Tory MPs in total disarray.

Telford's Tory MP Lucy Allan, perched uncertainly in a seat which has a Labour council and now stands to lose its emergency hospital services, has oscillated between denouncing NHS "bureaucrats" and "highly paid hospital managers who thought they knew what was best for us," and blaming "the Welsh lobby" whose needs had been "prioritised over those of Telford".

She is now apparently living in denial of the impact of the decision that has been taken, and on the one hand bending the ear of the Health Secretary with advice to withhold the £312m to finance the new hospital unless Telford retains a 24/7 consultant-led A&E, and on the other looking to her hero Boris Johnson to step in, claiming rather incongruously that:

"The NHS is at the heart of this Government's domestic agenda …. **This is not a Government that will take much needed hospital services from former mining towns, with poor health outcomes, to move these services to the Tory shires**. … Future Fit is out of time and Boris Johnson must put a stop to it."

By contrast her neighbouring Tory colleague Mark Pritchard, in the adjacent Wrekin constituency has happily accepted Matt Hancock's decision to back the controversial Future Fit plan, arguing it's now time to "trust the medical experts" and claiming the Independent Review Panel "say ministers should keep their noses out".

However even Pritchard is not prepared to "trust the medical experts" on another Future Fit proposal – to shift women and children's services from Telford to Shrewsbury – which he says he will fight to stop.

Both of these Tories with counterposed views are focused on the central fudge in Hancock's decision: while giving the go-ahead to the reconfiguration plan, he baulked at the political impact of axing A&E services in Telford, which has a large, relatively deprived population with a growing proportion of over-65s. So he came up with a weasel phrase, which he hoped might defuse some of the anger:

"Having listened to and accepted the advice of independent clinical experts, I have asked NHS England to come forward with proposals within a month on how they will keep the A&E in Telford open as an A&E Local so that the Princess Royal Hospital can continue to deliver the urgent and emergency care the residents in the growing town of Telford need."

Without beds for the most serious cases Telford will not have an A&E: it could be dangerously misleading to suggest otherwise.

Evasive

Of course nobody knows what an A&E Local is: the phrase is used vaguely once in the NHS Long Term Plan, but no example exists.

Even when asked by the HSJ to explain, NHS England gave only vague and evasive answers, although it is clear that Telford cannot be both an urgent care centre AND an "A&E Local".

But the one thing local Tory MPs appear to agree on is building up a fanciful notion of the "A&E Local," seeking to convince local people that it really means A&E services will remain in Telford. Mark Pritchard declares:

"I am also glad the Department of Health has made it clear that Telford's A&E should be retained with a new state-of-the-art 'A&E Local' model. It incorporates the very latest cutting-edge thinking on how A&E care should be provided. This involves building on, and providing much more than the previously suggested Urgent Care Centre model. It means more consultant-led time at Telford. This is good news."

Lucy Allan began with questions, asking "What I want to know is what is an A&E Local and what this will mean for my constituents," but soon shifted to echo Pritchard's insistence it means effectively retaining the A&E department that Future Fit proposed to axe: "I am seeking 24/7 consultant-led A&E at Telford."

She went on: "The hospital trust has always been strongly opposed to this model and are continuing to resist this proposal.… It's wholly unacceptable that SaTH can choose to opt out of providing services in Telford at their discretion. They need to compromise. They cannot have it all their own way. The NHS is a public service."

However the Reconfiguration Panel's report that was accepted by Matt Hancock stresses repeatedly the need to concentrate emergency services in a single site. Calling for the new model of hospital care to be "implemented without delay" the IRP pulls up well short of Hancock's ambivalent proposal for an "A&E Local" and stresses the limited urgent care provision at Telford:

"The Panel has previously commented about the confusion caused by the inconsistent use of names and models across the NHS and it is hoped that the current national policy to implement a standard urgent treatment model will improve matters. …

"Accepting the constraint that acute admissions will not be available at PRH, the Panel agrees that the aim should be to provide as much clinically appropriate urgent care and treatment as possible at the hospital."

However without beds for the most serious cases Telford will not have an A&E: it could be dangerously misleading to suggest otherwise. Indeed the "A&E Local" formula could cause problems and delays for patients who need to be admitted to a bed in Shrewsbury, but who would be in a "place of safety," and therefore not a priority as far as emergency ambulance services are concerned.

On a wider view, the IRP report is striking for its lack of any explanation of benefit to Telford's population from the Future Fit changes.

It contains no serious consideration of the needs of Telford's population which it admits has "higher than national rates of poor health with lower life expectancy and higher rates of people reporting long term limiting health problems or disability. Within the Borough, 15 areas are ranked in the 10 per cent most deprived nationally."

Campaigners' arguments rejected

Hancock and the IRP have now rejected the arguments of the Council and calls from Shropshire Defend Our NHS to retain both A&Es and expand community services.

But there are many more stages to go through before any new build, not least resolving what is meant by an A&E Local, and addressing the affordability gap of £100m or so between the plan and the £312m available.

The Shrewsbury & Telford Hospital Trust will need to develop a new 'strategic outline case' for the changes setting out how the money will be spent: once this is agreed the trust must then develop an outline and then a full business case before making its planning applications for any physical changes made to hospitals in Shrewsbury and Telford.

During this process there could be a legal challenge to the decisions that have been made.

Don't hold your breath waiting for a conclusion.

Squeezing out Telford

The IRP report sets a worrying precedent, by accepting that once a Joint Health Oversight and Scrutiny Committee had been set up between Telford and Shropshire councils, the JHOSC became "the appropriate **and only** English scrutiny body with which the CCGs must consult on any proposals developed in respect of the Future Fit Programme."

The JHOSC has proved an effective way for Shropshire and NHS bosses to sideline Telford council and brush aside its concerns. NHS England was no longer required to keep Telford informed or deal with them directly at all.

So when Telford council argued in challenging the Future Fit plans that the consultation with the JHOSC was inadequate in terms of both content and time allowed, the IRP response was to dismiss the complaint because – not surprisingly – the complaint "was not endorsed by the JHOSC or the other party to the JHOSC, Shropshire Council."

Compass staff strike again

Around 300 staff employed by private contractor Compass within NHS trusts in St Helens and Blackpool have also taken three days of strike action – angered by the company's failure to match health service pay rates and working conditions.

UNISON has condemned Compass for silencing its workers, after the firm disciplined hospital workers at St Helens & Knowsley Teaching Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust who had spoken out about low pay. UNISON regional organiser Pat Woolham said:

"It's plain that Compass is aiming to silence the strikers and suppress staff in an attempt to force them back to work. But the strikers are united, determined and will take further action if necessary." The September action was the third round of action on the issue by these hospital workers.

● More strikes have been called for 14/16/18/20/22/24 October

CCG mergers still avoiding any public consultation

The chief officer driving through the merger of five CCGs in Norfolk and Waveney boasts in a letter to a local councillor of having had responses from 245 members of the public, giving an indication of how few people are being consulted on these changes across the country.

As ***The Lowdown*** has reported NHS England is stepping up the pressure for groups of CCGs to merge. And while one planned merger – of the six CCGs in Staffordshire – has now been formally scrapped after a majority of GPs in five of the CCGs voted to reject the idea, GPs in other areas appear to be much less savvy and proactive. In Norfolk and Waveney all member GP practices of the CCGs were asked to vote, and 91% of the votes cast were in favour.

Campaigners have argued that one of the reasons behind the drive to merge CCGs into such large units is to further minimise any local voice or dissent while controversial closures and downgrades of hospitals and services are pushed through, although few CCGs have any great track record of standing up for local communities.

In a grim reminder of the lamentable record of many local councils in fighting for local health services, all three Health Overview and Scrutiny Groups for Norfolk, Suffolk and Great Yarmouth and Waveney agreed with CCG bureaucrats a full "public consultation" was not required, and nodded through proposals to significantly reduce any local accountability of NHS services.

However unlike CCGs, council health and scrutiny committees (which retain powers which date back to the 1970s to delay and challenge changes in services) are comprised of elected members.

So despite their current feeble showing they could yet be made into a last vestige of local accountability in the event of any controversial changes in an increasingly monolithic and bureaucratic "integrated" NHS.

Quality Improvement is best done by health staff, not academics

John Lister

What the (research) papers say

Staff in hospital departments, mental health and community services should be engaged in efforts to improve systems and the quality and efficiency of services.

This type of quality improvement (QI), or service improvement involves a study of the way systems work and may involve a study of alternative ways of organising: but is not "research" as understood by academics.

Indeed it is important to resist the efforts by academics to turn quality improvement into an academic pursuit, or one carried out by specific separate QI departments and handed down to staff at the front line.

A recent BMJ 'essay' by a high-flying Cambridge academic, How to improve healthcare improvement is undermined from the outset by getting this wrong.

The author, Mary Dixon-Woods, appears to set off in a promising direction, warning of the inadequate focus on quality improvement, on learning from failures and seeking to ensure systems have "the preconditions for high quality, safe care: funding, staff, training, buildings, equipment, and other infrastructure."

But she goes on to question the effectiveness of quality improvement in improving quality – not by comparing the performance and outcomes of departments and trusts before and after initiatives have been implemented, but on the basis of an absence of randomised control trials.

US quality expert Don Berwick made clear back in 1996 that this was not a useful way to assess such work:

"When we try to improve a system we do not need perfect inference about a pre-existing hypothesis: we do not need randomisation, power calculations, and large samples. We need just enough information to take a next step in learning.

"Often a small series of patients or a few closely observed events contain more than enough information for a specific process change to be evaluated, refined, or discarded, just as my daughter, in learning to ride her bicycle, sometimes must fall down only once to learn not to try that manoeuvre again."

Much QI work takes place on a day to day basis within well-managed departments seeking to improve their performance, and is not written up into peer-reviewed academic papers.

The starting point must be what Berwick describes as the Central Law of Improvement: "every system is perfectly designed to produce the results it achieves".

So if we want to improve the quality of care delivered, we have to improve the system, and address any gaps, delays, confusion and other weaknesses that impede or undermine patient care.

Moreover if a quality improvement exercise results in a reduction in hospital-acquired infection – perhaps by improved and more frequent cleaning of doctors' stethoscopes, for example, or similar measures – there is no sense in then adopting a randomised control trial in which some patients are put at greater risk by research in which some doctors act as the "control" by not cleaning their stethoscopes.

Much QI work takes place within well-managed departments seeking to improve their performance, and is not written up into peer-reviewed academic papers.

The process for quality improvement advocated by Berwick, by the US Institute for Healthcare Improvement and by British advocates (including the 1000Lives Plus initiative in Wales) is the implementation in the workplace of a "plan-do-study-act (PDSA) cycle".

Berwick sums this up as inductive learning – "he growth of knowledge through making changes and then reflecting on the consequences of those changes."

He argues that "… the enterprise of testing change in informative cycles should be part of normal daily activity throughout an organisation."

If it's a part of normal daily activity, it's not academic research. Berwick says this method represents a democratisation of scientific method.

This is very different from the way academics seek to find a role for themselves and subject any area of inquiry to their own assumptions.

Ms Dixon-Woods argues some QI efforts, "perversely, may cause harm—as happened when a multicomponent intervention was found to be associated with an increase rather than a decrease in surgical site infections."

Had this intervention adopted a PDSA approach it would have been stopped as soon as there was any evidence of harm being done.

She also cites a study by a team including Lord Darzi that attempts to assess peer-reviewed publications of PDSA cycles but which complains that they show an "inconsistent approach" but "does not conclude whether better application of the PDSA method results in better outcomes."

Academics are unhappy with an approach that shows academics and their methods to be unnecessary and even unhelpful.

Even Dixon-Woods admits that "not all improvement needs to involve a well defined QI intervention, and not everything requires a discrete project with formal plan-do-study-act cycles."

Indeed the second page of her essay is considerably more constructive than the first, noting that "many high performing organisations, including many currently rated as outstanding by the Care Quality Commission … use structured methods of continuous quality improvement.

"But studies of high performing settings … indicate that although continuous improvement is key to their success, a specific branded improvement method is not necessary."

She also criticises mental health and learning disability services for paying much less attention than acute hospitals to quality and safety improvement.

So the essay serves as a useful spur to discussion of how services can be improved for patients through the involvement of the staff who care for them and addressing systemic problems rather than individual skills and behaviour.

Some of the right answers are included for those who stay the course and plough through a first page which is littered with the wrong ones.

Looking closer at Johnson's "fake forty" hospital plans

John Lister

It has been hard to keep up with and evaluate the succession of announcements of new money for refurbishment and building projects that have emerged since the beginning of August.

The two major announcements were of £1.8 billion in capital to "upgrade outdated facilities and equipment" in early August, and the commitment at the end of September to provide another £2.7 billion to fund six new or refurbished hospital projects, with "seed funding" for another 34 postponed future projects – which will potentially cost another £10 billion or more – after 2025.

From the outset there has been scepticism on where the money is to come from. and whether or not more than half of the initial £1.8 billion for capital projects was new money at all: it was swiftly revealed that £1 billion of it was money already in Trust accounts, but which they were forbidden to spend by NHS England in a 20% cutback as recently as July this year.

King's Fund chief executive Richard Murray said it was "difficult to tell how generous the government is being, given a lack of clarity over how the schemes had been selected, and how the pledges fitted within the department's overall financial settlement."

The Office for Statistics Regulation has since stepped in to call for more accuracy in ministerial claims.

It was only some time after this first initial announcement that any details emerged on what schemes were to result from the extra money, and a list of 20 was unveiled, totalling £850m.

They are a mixed bag, in which 3 primary care projects for almost £100m, two mental health projects totalling £112m and a new unit for Learning Disabilities for £33m were outstripped by 14 projects in acute hospitals – an imbalance that has continued in the subsequent announcements of "new hospitals".

The remaining £1 billion has now been released to be spent by trusts on the various projects that had been halted or cut back.

"The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year)."

Some hospitals are promised future cash and new buildings: others like Weston are still facing cash-driven A&E closures

Capital-starved NHS

Some of the process of claim and counter-claim over the figures will have conveniently distracted from the harsh fact that, as the Labour Party has pointed out, in excess of £4 billion has effectively been cut or siphoned out of NHS capital budgets since 2014, much of it used to prop up trusts' revenue budgets.

Indeed a hard-hitting campaign by NHS Providers, the body representing trusts, puts the figure even higher and calls for sustained increases capital funding for several years. They argue that:

"The NHS buildings and equipment budget has been relentlessly squeezed year after year. Over the last five years we've had to transfer nearly £5bn of that money to prop up day to day spending. As a result, the NHS now has a maintenance backlog of £6bn, £3bn of it safety critical. The NHS estate is crumbling and the new NHS long term plan can't be delivered because we don't have the modern equipment the NHS needs."

A more detailed NHS Providers briefing document published at the end of August, arguing the case for restoring and increasing levels of capital funding, raises the shocking fact that:

"The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year)."

It's not surprising therefore that while welcoming the promise of any extra money for new buildings, NHS Providers was less than ecstatic about the over-hyped claims to be giving an immediate go-ahead for 40 hospitals, and keen to emphasise what was still a vital missing element:

"The NHS has been starved of capital since 2010. There's a £6bn maintenance backlog, £3bn of it safety critical. It's not just these six hospitals who have crumbling, outdated, infrastructure - community and mental health trusts, ambulance services and other hospitals across the country have equally pressing needs. We also need increased capital spending to support changes in the way care is delivered, including in IT and digital, to deliver the new NHS long term plan."

Some of the projects appear to overlap with each other: a £99m scheme for a new children's hospital in Truro among the 20 projects funded in August, for

Continued next page

example, followed by inclusion of Cornwall on the list of trusts receiving "seed funding" for what was initially trumpeted as 40 new hospitals.

Then there was the 24 hours of uncertainty created by PM Johnson's off the cuff statement on September 30 at Conservative Party conference that a new hospital in Canterbury was to be included on the list of new hospitals, triggering all kinds of responses from confused local MPs and campaigners – only to find that no new projects in Kent were included at all.

Three lists of promises

So what has been agreed, where is the money going, and when, if at all, will the promised new projects begin to take shape?

There are three distinct lists of projects: the initial £1.8 billion (more than half of which has not been explicitly allocated); the list of six new hospitals given the "immediate" go-ahead; and the list of 21 trusts given a share of £100m of "seed funding" to work up projects to commence some time after 2025.

If these three lists are combined, the geographical distribution favours the **East of England** (11 projects) and the **North West** (10), in each case five of the projects allocated only "seed funding" and deferred to some time after 2025.

The **South East** is least favoured, being promised just 4, three of them post 2025 and one lump of £48m to redesign acute services on the **Isle of Wight.** The **North East & Yorkshire** region also has 4 projects, three from the £1.8 billion, and one of the more immediate projects – a development at **Leeds General Infirmary**.

Six of the seven projects announced for the **South West** are in the far future time frame beginning 2025.

The electioneering aspect of the proposals should not be forgotten either. Shadow Health secretary Jonathan Ashworth has also pointed out that **eight of the 21** future projects cover Tory marginal seats, where even a tenuous promise of a new hospital might win a few extra votes: he named **Hastings, Eastbourne, Winchester, Plymouth, Reading, Truro, Torbay, Barrow** and **Uxbridge**.

Backlog bills

A closer look at the allocations from the £1.8 billion shows that three of the major acute hospital trusts stand to receive sums that are only a small fraction of their backlog maintenance bill: for **Newcastle Hospitals** this was £116m at the last count, **Stockport** needed £94m and **United Hospitals of Lincolnshire** £78m. So even after the belated "extra" money is received each of these trusts will still face hefty and unpayable bills for repairs just to bring their buildings up to standard.

Wye Valley NHS Trust has finally been allocated the money to replace the 1940s-built hutted wards that should have been demolished as soon as the PFI-funded hospital in **Hereford** opened in 2002.

The relatively small sums included in this list also underline the extent to which trust finances have been squeezed in recent years, making even relatively modest projects and what should be routine maintenance and replacement of equipment unaffordable without additional support.

No instant start

Of the six new hospitals that have been given the immediate go-ahead, none is ready to start work for some months to come: most will takje much longer.

In **South West London** the long-running saga of the replacement of the crumbling **St Helier Hospital** in Carshalton that has dragged on for more than two decades is revived once again. Management of the **Epsom & St Helier** trust have decided the debate is about where to build a new £400 million "major acute" hospital.

Local people were once promised public money would be available to rebuild St Helier: but that promise was broken. Now they are promised Epsom and St Helier hospitals would both be retained as "district hospitals" – but a pale shadow of the current hospitals, with primarily outpatient and diagnostic services, an urgent treatment centre – and little more than half the 748 'core beds' that were available in Epsom and St Helier earlier this year. An 'Issues' document last year stated clearly that "any potential solution with more than one major acute site … is eliminated".

Local health chiefs now have to run a full public consultation in which they state where the new hospital should be, followed by development of a full business case. This story could run and run.

In **North East London** the announcement that the money is available will relaunch a similarly long wrangle over the funding and size of a new hospital to replace the ageing **Whipps Cross Hospital**, now subsumed into the morass of the **Barts Health Trust**. As with Epsom & St Helier the discussion has not yet even clarified where on the extensive Whipps Cross site the new building should be located.

After so many NHS capital assets have been sold off and the proceeds swallowed up covering trust deficits there will be some local concern at a "masterplan" suggesting a "new, taller, building on about one-fifth of the site" and alarm at the prospect of selling off the remainder of the estate "for much-needed new homes and community facilities."

In **Leeds**, too, where the **Teaching Hospitals Trust** has been given the green light to proceed with building new hospitals for adults and children on the Leeds general Infirmary site, the Trust board is far from ready to begin work at once: "The Trust has a number of stages to complete before it can start building the new hospitals, but expects the build to take around three years once it is underway." And as with Whipps Cross the project brings the prospect of land and buildings being sold off "to support the development of a new Innovation District for Leeds". Some, like the Grade I listed Gilbert Scott Building "will be offered for sympathetic redevelopment to preserve their fantastic heritage for the city."

In **Watford West Hertfordshire Hospital Trust** bosses have been "thrilled" by the funding to build a replacement. But there is also an unresolved argument over the location of an acute hospital to serve the catchment area of almost 500,000 people, with non-Watford residents arguing strongly for a new build on a site that is not caught up in Watford's congestion and proximity to the Premier League football ground.

Watford was selected as the main emergency hospital because at that time it was a very important 3-way marginal constituency: but it is the most inaccessible. It can take an hour or more by car from St Albans or Hemel Hempstead at 8am. By bus it is far worse – taking one and a half hours most times.

The problem will now have to be aired again with the development of a Business Case: the Trust has promised to share their proposals "as soon as possible": the arguments will resume over how best to invest for future access to health care.

In **Harlow**, the announcement that the **Princess Alexandra Hospital Trust** is free to build the long-awaited and interminably-discussed new hospital has also left management "thrilled" but brought warnings that there will be some delay before anything actually happens. Chief Executive Lance McCarthy said: "We can now put into action our plans to speak with local people about their thoughts and suggestions on the new hospital to make sure that it meets their needs into the future."

Princess Alexandra is a small hospital built in the 1960s for a much smaller caseload and which ended winter 2017/18 with bed occupancy above 99%: just 67% of A&E attenders treated or discharged within the target 4 hours.

Continued next page

Nothing for mental health

Responses from the Health Foundation and NHS Providers to the funding announcements have flagged up ministers' focus on headline-grabbing voter-friendly acute hospital projects, and the grossly inadequate share of the new resources going to expand community health services, primary care and in particular mental health:

"None of the six hospital trusts given funding to develop a new hospital or the 21 trusts given seed funding in the government's health infrastructure plan, and just three of the 20 hospital projects which received funding earlier in the summer, are mental health trusts."

A new NHS Providers Framework for Community Mental Health points out the huge gap in provision that has opened up as a result of inadequate investment:

"Core community services are a fundamental element of mental health provision. However, they have suffered from a lack of investment in recent years which has significantly impacted the quality of services and people's access to them. Our report *Mental health services: addressing the care deficit*, found 85% of mental health trust leaders do not feel there are adequate mental health community services to meet local needs."

NHS Providers' analysis shows that the failure to prioritise investment in the mental health estate is having a real impact on patients:

The number of reported patient safety incidents caused by infrastructure (staffing, facilities, environment) in 2018/19 was 19,088 compared to 17,693 in 2017/18. "These incidents include unsafe environments with a risk to personal safety and inappropriate clinical environments."

The number of infrastructure incidents, such as inappropriate disposal of clinical waste or wards that are too hot or too cold, in mental health trusts has increased by 28% from 2015/16 to 2018/19, compared to a 16% increase for incidents in all trusts.

There were seven never events reported in mental health trusts in 2018 as a result of a shower/curtain rail failing to collapse and one as a result from a fall from a window.

Eight of the 21 future projects cover Tory marginal seats, where even a tenuous promise of a new hospital might win a few extra votes

Trusts allocated money from from £1.8 billion for upgrades & new equipment

NHS organisation	Acute hospital	Mental health & LD	Primary care
Luton & Dunstable University Hospital	99.5		
Norfolk & Norwich University Hospitals	69.7		
Norfolk and Suffolk NHS FT		40	
NHS South Norfolk CCG			25.2
University Hospitals Birmingham	97.1		
United Lincolnshire Hospitals Trust	21.3		
Wye Valley NHS Trust	23.6		
University Hospitals of North Midlands	17.6		
Barking, Havering & Redbridge CCGs and NE London NHS Foundation Trust			17
Croydon Health Services NHS Trust	12.7		
South Yorkshire and Bassetlaw Integrated Care System			57.5
The Newcastle upon Tyne Hospitals NHS Foundation Trust	41.7		
Leeds Teaching Hospitals NHS Trust	12		
Greater Manchester Mental Health NHS Foundation Trust		72.3	
Mersey Care NHS Foundation Trust		33	
Stockport NHS FT	30.6		
NHS Wirral CCG	18		
Tameside and Glossop Integrated Care NHS Foundation Trust	16.3		
Isle of Wight NHS Trust	48		
Royal Cornwall Hospitals NHS Trust	99.9		
Totals	608	145.3	99.7

Dr Neil Clifton, CC BY-SA 2.0, https://commons.wikimedia.org/

St Helier Hospital in Carshalton SW London in 2012: the banner boasts a new hospital is "coming soon"

Whipps Cross "master-plan" is for a "new, taller, building on about one-fifth of the site"

List of hospital building projects given go-ahead or "seed funding"

Trust	Hospital(s)	Total backlog maintenance (£m) (2017-18)	DHSC loans to Trust (£m)	Control total/ planned deficit (£m)
Barts Health	Whipps Cross Hospital	78	149	65.3
Epsom & St Helier	Epsom, St Helier & Sutton Hospitals	108	n/a	6.7
Leeds Teaching Hospitals	Leeds General Infirmary	58	89	5.2
Princess Alexandra	Princess Alexandra Hospital	29	66	28.4
University Hospitals Leicester	Leicester General, Leicester Royal, Glenfield	77	209	48.7
West Hertfordshire Hospitals	Watford General	27	195	22.7
	Wave 1 combined loans propping up trust finances		708	
	Wave 1 Total of backlog maintenance unresolved	377		
	Wave 1 combined planned deficits 2019-20			177
21 Wave 2 trusts sharing £100m "seed funding"				
Cambridge University Hospitals	Addenbrookes Hospital	101	403	33.1
Dorset Healthcare	Up to 12 community hospitals	0.7	n/a	-2
East Sussex Healthcare	Conquest & Eastbourne District Hospitals	35	203	30.4
Hampshire Hospitals	Royal Hampshire, Basingstoke & N. Hants Hospital	67	19	-12.2
Hillingdon Hospitals	The Hillingdon Hospital	109	76	24
Imperial College Healthcare	Charing Cross, St Mary's and Hammersmith	660	34	16
James Paget University Hospitals	James Paget Hospital	22	13.8	5.5
Kettering General	Kettering General	42	149	0
Lancashire Teaching Hospitals	Royal Preston Hospital	27	166.5	37
Milton Keynes NHS FT	Milton Keynes Hospital	8	127	0.4
North Devon Healthcare	North Devon District Hospital	9	18	0
Nottingham University Hospitals	Queens Medical Centre, Nottingham City Hospital	136	120	27
Pennine Acute Hospitals	North Manchester General Hospital	3	155	24.5
Plymouth Hospitals	Derriford Hospital	0.5	109	0
Royal Berkshire NHS FT	Royal Berkshire Hospital	50	17.2	-1.5
Royal Cornwall NHS FT	Royal Cornwall Hospital	41	63	0
Royal United Bath NHS FT	Royal United Bath Hospital	46	17	-7.8
Taunton and Somerset NHS FT	Musgrove Park Hospital	22	22	6
Torbay and South Devon NHS FT	Torbay District Hospital	30	90	-1.7
University Hospitals Morecambe Bay	Royal Lancaster Infirmary, Furness General Hospital	38	233.8	60.1
West Suffolk NHS FT	West Suffolk Hospital	26	96	0
	Wave 2 combined loans propping up trust finances		2132.1	
	Wave 2 Total of backlog maintenance unresolved	1,473		
	Wave 2 combined planned deficits 2019-20			238.8

There has been a debate over whether to patch up the existing building or replace it with a new £450m hospital on a "new" site, which may or may not be close to PAH. A Commons adjournment debate in June 2018 brought the statement from Health Minister Stephen Barclay that the STP bid for £500-£600 million to develop a new hospital and health campus on a greenfield site to replace the old hospital had been whittled down to £330m and referred back to NHS Improvement.

Local Tory MP Robert Halfon pressed the urgency of investment: "A 2013 survey rated 56% of the hospital's estate as unacceptable or below for its quality and physical condition. That was five years ago now and the situation is only deteriorating. With long-term under-investment, we are continuing to put the capability of the hospital to care for those in need at serious risk—just read the reports of raw sewage and rainwater flowing into the operating theatres."

However it's clear there will be a considerable delay between the new allocation of funds and the first bricks being laid in Harlow.

Likewise in **Leicester,** where the decision to give the go-ahead to the hospitals Trust to implement its reconfiguration of services is a sharp reminder of the unresolved debates over how services should be organised. Leicestershire and Rutland have just one acute hospitals trust, **University Hospitals of Leicester (UHL)**, operating on three sites: for many years there have been plans to reduce this to two, with the loss of acute beds and services at Leicester General Hospital.

Now Chief Executive John Adler, professing himself "ecstatic" at the news that £450m is now available, has underlined this two-site strategy, arguing that the money would be enough for:

- A new Maternity Hospital and dedicated Children's Hospital at the Royal Infirmary
- Two 'super' intensive care units with 100 beds in total, almost double the current number
- A major planned care Treatment Centre at the Glenfield Hospital
- Modernised wards, operating theatres and imaging facilities, and
- Additional car parking

A pre-consultation business case, reputed to be a staggering 1800 pages long has been kept carefully under wraps, apparently for fear local campaigners would begin to discredit its arguments before the carefully-spun official version could be established with local news media.

So the announcement that funding is in place for the reconfiguration heralds a fresh round of argument at local level. Campaigners will once insist that concentrating all the Trust's emergency and most inpatient services on the already congested Leicester Royal Infirmary site makes little sense.

Before any new building can commence the Trust needs to brace itself for a full public consultation and construct a viable Business Case – which could also be open to challenge.

Impact on backlog

In total it seems that the six "new hospital" projects could eliminate up to £377m of the £6 billion backlog maintenance bill in England.

However the six trusts are already deep in the red, with combined loans to prop up their finances totalling over £700m, and planned deficits this year of £177m, so the terms on which the money is to be made available for the projects could make all the difference to their affordability.

In Leicester a pre-consultation business case, reputed to be a staggering 1800 pages long has been kept carefully under wraps, apparently for fear of local campaigners

Leicestershire's fantasy road to reconfiguration

The remaining 21 trusts that will receive less than £5m each in "seed funding" to begin to work up plans to begin in the mid 2020s are unlikely to see any major new building until at least 2027 – and some will have to find ways to manage some very significant backlog maintenance bills.

The biggest by far, and biggest backlog in the NHS is **Imperial Healthcare** which needs £660m to tackle **St Mary's Hospital** and its other sites, but will receive nothing for at least six years. Three other hospital trusts (**Cambridge University, Hillingdon** and **Nottingham University**) face backlog maintenance in excess of £100m.

Borrowing

While several of the 21 trusts whose needs have been put on the back burner are actually projecting a break-even or surpluses on revenue spending this year, many are relying on rolling over and increasing loans from the Department of Health that have helped pretty up their balance sheets: these total more than £2.1 billion.

However at least these trusts have the distant hope of some relief: many other trusts across the country face onerous backlog maintenance bills but do not appear on any of the lists of trusts singled out for extra cash. They have no prospect of being able to upgrade or replace their decrepit buildings.

Behind Johnson's bravado, and the obedient gratitude of trusts handed back part of the money they should have had over the past nine years, is a stubborn and growing problem of backlog maintenance, and continued neglect of investment in mental health, community and primary care services.

There is also a prospect of growing frustration in many areas where people may have taken the announcements as good coin, and may respond angrily when they see no change in their local hospitals.

Worse, if Johnson succeeds in pushing through a no-deal Brexit and the warnings of the Institute of Fiscal Studies prove accurate, there would be serious doubts over the promises of future funding six years down the line. Even with "substantial" government spending, the IFS expects the UK economy to flatline for two years, and forecasts government borrowing rising to £100bn.

The IFS warns that any rise in public spending in 2020 would likely be followed by "another bust" as the government would have to deal with "the consequences of a smaller economy and higher debt for funding public services.

IFS boss Paul Johnson summed up:

"An economy that turns out smaller than expected can, in the long run, support less public spending than expected, not more."

Trusts with backlog maintenance of more than £30m, not on any list

Trust	Backlog £m
London NW Hospitals	200
Sheffield Teaching Hospitals	120
St Georges	99
Sandwell & West Birmingham Hospitals	91
East Kent Hospitals	72
Oxford University Hospitals	69
Doncaster & Bassetlaw	67
Medway Maritime Hospital	58
Kingston Hospital	57
Heart of England	48
Royal Free Hospital	47
Mid Cheshire Hospitals	43
Salisbury Hospital	42
Gloucestershire Hospitals	36
Lewisham & Greenwich Hospitals	32
Brighton & Sussex Hospitals	34
Buckinghamshire Healthcare	31
SW London & St George's Mental Health	30
Total	1176

Birmingham's Midland Metropolitan hospital left stranded by collapse of Carillion could be the last PFI hospital completed

HIP, HIP hooray?

New policy 'retires' PFI – but sidelines mental health

John Lister

Since the flurry of main announcements the Department of Health and Social care has published a Health Infrastructure Plan (HIP) as "a new strategic approach to improving our hospitals and infrastructure".

It offers few surprises. The same gaps and skewed priorities that can be seen in the first round of allocations under the Johnson government run through the HIP.

There are no new resources to tackle the rising bill for backlog maintenance, even though the scale of the problem is referred to on page 9:

"There is significant unmet demand for capital in the system. A key example of this is that the NHS is reporting significantly increasing levels of backlog maintenance, up 37% between 2014-15 and 2017-18 to £6.0bn, with the highest risk category ('significant') rising most rapidly."

Backlog: trusts left to cope

But by page 11 this had shifted to a general aspiration for an NHS that "proactively takes steps to maintain assets and reduce backlog maintenance," and by page 17 the problem has been deftly shuffled back onto the trusts themselves to pull themselves up by their own bootstraps:

"… Taking responsibility for the on-going 'business as usual' maintenance of their healthcare estates, ensuring they are sufficiently surveyed, and sensible investment decisions are made and prioritised accordingly."

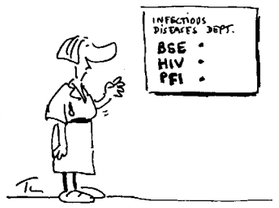
Similarly the HIP offers no hope for trust boards, management and staff trying to deliver mental health services in decrepit and unsuitable buildings. It begins with brave words on page 6:

"The HIP is not just about capital to build new hospitals – it is also about capital to modernise mental health facilities, improve primary care and build up our infrastructure in interconnected areas such as public health and social care …"

The same platitudes are repeated on page 14, but the document contains no commitments to any significant investment to make this possible, and it's clear that the promises, if any, will only come in the future:

"The full shape of the investment programme will be confirmed when the Department for Health and Social Care receives a multiyear capital settlement at the next capital review and will feed into the phases of HIP – and at that point an updated version of this document will be published."

So these priorities for the NHS are ignored and 93% of the £3.7 billion of new money is focused on the acute hospital sector.



Nail in coffin of PFI

However there are some new aspects to be noted in the HIP, most notably banging the final nail into the coffin of the Private Finance Initiative, a failed Tory policy which the Johnson government is now keen to link to the Blair government, which implemented it with most vigour in the NHS.

The HIP (page 9) has a clear commitment to public funding of any new hospital development:

"The retirement of off-balance sheet government-funded infrastructure (formerly known as "PFI" or PF2) has also removed a significant source of funding from the system, given the majority of new acute provision over the past 20 years has come through PFI. **It is therefore clear that public capital funding will be needed to deliver new large hospital replacements in the future**."

Former NHS finance director and analyst Roger Steer, speaking to ***The Lowdown***, pointed out the limitations of the HIP as a strategy:

"While some chosen projects have received good news the reverse of the coin is that the announcements represent years of delay for other projects, equally as urgent and pressing. Projects should be receiving capital and revenue support based on need and the quality of the business case; and shouldn't be required to wait in a queue for years.

"£2.9bn only represents a proportion of backlog of projects built up over the years and the total bids for capital in the STP plans of 2016 added up to more than £20bn.

"The other word of caution is that the Treasury is not mentioned once. It is clear that this is a hasty announcement that may not have the Treasury's full backing.

"If the economy nosedives after Brexit we may be back to stop in the stop –go cycle, with capital spending as the first item on the list of cash savings."

"The majority of new acute provision over the past 20 years has come through PFI. It is clear that public capital funding will be needed to deliver new large hospital replace-ments in the future"

Battle for fair pay from contractors

September has been a month for industrial action by staff employed by contractors – especially in the North West.

Engie

The latest to join the fray have been staff employed by private contractor Engie Services Ltd within Salford Royal NHS Foundation Trust have unanimously voted to take strike action over their employer's failure to pay NHS rates.

They work for the multinational outsourcing company as security guards and some are paid only the minimum wage rate of £8.21 an hour. The lowest rate for staff employed directly by the NHS is £9.03 an hour and the difference of 82p an hour is worth £1,500 a year for full-time staff.

UNISON North West regional organiser Amy Barringer said: "Security staff put themselves in danger to keep patients and staff safe. The 100% mandate for strike action shows how strongly these dedicated hospital staff feel about this issue. Engie must put hands into pockets and do the right thing before hospital security staff are forced to take strike action."

Compass

Around 300 staff employed by private contractor Compass within NHS trusts in St Helens and Blackpool have also taken three days of strike action – angered by the company's failure to match health service pay rates and working conditions.

UNISON has condemned Compass for silencing its workers, after the firm disciplined hospital workers at St Helens & Knowsley Teaching Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust who had spoken out about low pay.

UNISON regional organiser Pat Woolham said: "It's plain that Compass is aiming to silence the strikers and suppress staff in an attempt to force them back to work. But the strikers are united, determined and will take further action if necessary."

The September action is the third round of action on the issue by these hospital workers.

Addaction

In Wigan 31 drug and alcohol support workers employed by Addaction are have been taking action over pay and broken promises. The staff were previously employed by the NHS but the service, commissioned by Wigan Council, was transferred to the London-based charity.

Workers continued to receive pay rises in line with those of NHS employees and were given assurances by the organisation's managers this would continue into the future. But when the 1% pay cap in the NHS was removed from April 2018, Addaction refused to implement the promised wage rise.

Chamber of Commerce fights to stop Cheltenham downgrade

An unusual but potentially powerful campaign against the downgrade of A&E and acute services at Cheltenham Hospital is being led by … the local Chamber of Commerce!

The challenge from this unlikely quarter has been triggered by the launch of Gloucestershire Hospitals Foundation Trust of a 'Fit for the Future' document which campaigners – and now business leaders warn is misleading. They have analysed the proposals and rewritten the questions it asks, to pose the issues more clearly for local people.

The main concern is plans to remove Cheltenham Hospital's emergency and inpatient general surgery. 57 consultants and senior doctors at Cheltenham General Hospital have signed a letter stating the move could put patients at risk. Cheltenham General serves a population of at least 200,000 in Cheltenham, Tewkesbury borough and the North Cotswolds.

A cross-party campaign group called REACH (Restore Emergency at CGH Ltd) is opposing the change, and has invited trade unions and campaigners to join in common cause.

It's chaired by Michael Ratcliffe, who is also Chairman of the Cheltenham Chamber of Commerce. He said:

"There has been a serious failure of due process, lack of transparency and lack of consultation. Shifting all major emergency and elective general surgery to GRH would be a grave mistake, and is strongly opposed by many eminent doctors.

"This 'pilot' also appears to be a full-blown service delivery change in all but name. So we make no apology for fighting these proposals tooth and nail, on behalf of the people of Gloucestershire and surrounding counties."

"We make no apology for fighting these proposals tooth and nail, on behalf of the people of Gloucestershire and surrounding counties."

REACH argues that the Fit for the Future plan involves six steps to downgrade Cheltenham General:

1) Downgrade the Accident and Emergency Dept, which would then be replaced by an "Urgent Care Centre", manned by GPs and not hospital emergency specialists.

2) Transfer all emergency and major inpatient general/bowel surgery from Cheltenham General to Gloucestershire Royal, leaving intermediate and minor day-case surgery only.

3) Move all interventional radiology and vascular services to Gloucestershire Royal

4) Remove out of hours surgical cover for sick patients at Cheltenham's Oncology Centre.

5) Threaten the future of the pelvic cancer surgery unit at Cheltenham General

6) Isolate the medical gastroenterology unit, which was centralised in Cheltenham General Hospital two years ago.

NHS chiefs insist they do not recognise REACH's analysis.

The new campaign follows loud complaints by the local Tory MP in early August that the plans meant the town's A&E unit was to be downgraded, and a call by the Conservative group leader on Cheltenham Borough Council, for an emergency meeting for the full council to back the call for these proposals to be "dropped completely."

Local NHS bosses paused their "engagement" process for a fortnight in response to these claims, before relaunching its drive to win public acceptance of its plans to create "centres of excellence" … in Gloucester, 10 miles away.

Safe staffing: it's not just about nurses and doctors

What the (research) papers say

JOHN LISTER looks at three recent academic papers and a book relevant to NHS campaigners

John Lister

In the past five years numbers of nurses in England have risen by 4.6%: but the numbers of hospital admissions have risen by 12.3%. One in nine nursing posts are vacant. But if nurses are to be brought back in to the profession and new students attracted they must be given the hope of delivering a safe, effective service to patients.

Campaigns for improved nurse staffing levels in NHS hospitals, many of them modelled on similar campaigns in the US, Australia or less ambitious proposals that have become law in Wales and Scotland, all tend to refer with more or less precision to the proportion of patients to qualified nursing staff.

There is indeed a clear link established between higher levels of admissions per Registered Nurse and increased risk of death during an admission to hospital. These findings highlight the possible consequences of reduced nurse staffing: they point to the need to reject policies that encourage the use of nursing assistants to compensate for shortages of RNs.

Queensland Nurses and Midwives Union – now setting their sights on securing legal minimum staffing ratios for care of older patients.

Hospital management and ministers in England have been primarily seeking to avoid adopting any fixed nurse:patient ratio, even steering clear of the suggestion of a maximum of 8 patients per registered nurse set out in the Francis Report.

In 2013 a report from the National Quality Board and Chief Nursing Officer, '***How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability***', rejected defined staffing ratios in favour of the use of "evidence, evidence-based tools, professional judgement and a truly multiprofessional approach."

In October 2015, a letter from 'arms-length bodies' to Trusts attempted to clarify contradictory messaging between requirements to achieve safe staffing and "the need to intensify efforts to meet the financial challenge." It argued that the 1:8 ratio that NICE had highlighted as a potential alarm bell to trigger review of staffing levels, should be treated as a "guide not a requirement."

NICE was told to stop work on ratios – not least because a quarter of trusts responding to surveys reported that the 1:8 level was being exceeded (i.e. more than 8 patients per registered nurse) on more than 65% of shifts.

In England management and government preference, especially in the light of staff shortages, and the problems of recruitment, has been to substitute warm words for hard action, despite evidence in California that firm action to ensure the quality of care helps recruit and retain nursing staff. UNISON's report 2017 Ratios not Rationing explained clearly the positive impact it can have:

"In California, the number of actively licensed registered nurses increased by nearly 100,000 following the enactment of a staffing ratio law. Vacancies for registered nurses plummeted when the ratios were first implemented and turnover and vacancy rates have fallen far below the national average. There has also been a dramatic increase in the number of students interested in nursing as a career. These improvements show that ratios could be the answer to the current staffing crisis in the health service in the UK."

In Queensland the introduction of a mandatory ratio "has saved almost 150 lives and helped the government save millions of dollars."

The most substantial recent case study outside England also points to the need for a fixed maximum ratio of patients per nurse – and far fewer than 8:1. In Queensland the introduction of a mandatory ratio "has saved almost 150 lives and helped the government save millions of dollars."

The study, reported in *Nursing Times* looks at the actual impact of imposing a legal ratio of one nurse to four patients for morning and afternoon shifts, and one nurse to seven patients for night shifts for selected acute surgical and medical hospital wards and mental health units across 27 hospitals in Queensland since July 2016.

"They have also avoided 255 readmissions and 29,200 hospital days, with an estimated cost saving of between $55.2m to $83.4m (£30.7m to £46.5m). In addition, the average nurse on wards included has seen their workload reduce by one to two patients during the day, and one to three on a night shift.

"Reductions of one patient per nurse were associated with a 9% less chance of a patient dying in hospital, a 6% less chance of readmission within seven days, and a 3% reduction in length of stay."

These are important findings, and undermine the routine claims of staff shortages and added cost.

But there is also evidence of the advantage of a proper skill mix on wards, which can also save lives.

A paper published during the summer in the BMJ

Hospital management and ministers in England have been primarily seeking to avoid adopting any fixed nurse:patient ratio, even steering clear of the suggestion of a maximum of 8 patients per registered nurse set out in the Francis Report

Quality and Safety points out the need for adequate staffing levels of "nursing support" – which in England are normally Health Care Assistants – not as any kind of substitute for registered nurses, but as important additional support.

The US-based study developed a data set to allow researchers to measure staffing for each unit and each shift.

Its findings that additional support staff alongside registered staff helped improve patient outcomes raise the question of whether this is because when support staff numbers are low, registered nurses wind up doing more of the work they would do, "such as delivering and retrieving food trays, transporting patients, obtaining supplies and equipment and arranging transportation" to the detriment of patient care.

The study also suggests that while support staff are "not formally trained in patient assessment and monitoring, nonetheless contribute to these tasks as part of their contact with patients and through a developed ability to recognise patients who may need attention by others on the staff."

"When nursing support staff are less available, this contribution to the safety of patients is reduced."

The evidence is clear: we need sufficient qualified staff per patient, supported by sufficient support staff – HCAs, clerical, housekeeping and porters – to allow them to do their job. Without the full team the safety of patients can be jeopardised.

The campaign needs to be taken forward to learn these lessons and demand safe staffing on NHS wards.

Does integration of services work?

John Lister

"Integration" has been a word often abused and confusingly used by NHS England: but do any of the projects carried out in its name actually deliver on their promises?

A new research paper examining whether or not integration of health and social care services can deliver the promised result of reduced demand on emergency admissions comes up with a guarded positive reply.

This is potentially important, since as the study points out:

"Reducing emergency admission rates has been a feature of English health policy over the last decade and continues to be one of the most commonly used measures of success for system change initiatives. To date, however, there has been little evidence of initiatives successfully reducing emergency admissions."

But the periods studied were several years ago, and we are not told which areas are being studied. The researchers were examining policies brought in by "pioneer" projects in England: but their study compares performance from a "pre-pioneer baseline period (April 2010 to March 2013) over two follow-up periods: to 2014/2015 and to 2015/2016."

The findings could be very different after another three years of austerity funding of the NHS and cutbacks in local government and social care budgets.

It is also notable that the 'baseline' period from 2010 came at a very early point in the imposition of what has become a virtual freeze on real terms NHS funding, and was also prior to the implementation of the 2012 Health & Social Care Act, which established Clinical Commissioning Groups and NHS England. So two very different periods are being compared.

The overt allocation of existing resources to the pioneer projects was limited: "Each pioneer was given access to limited support and expertise over a 5-year period and a one-off fund of £90 000 to help with initial development."

However given the focus on such 'pioneer' projects it's likely that these projects were less subject to cutbacks, staffing shortages and funding pressures than services elsewhere.

I can't tell you how sorry I am...your husbands death is really going to bugger up our weekly performance figures!

The result was hardly dramatic: the pioneer areas managed to slightly limit the increase in emergency admissions

Even so the result was hardly dramatic. The pioneer areas managed to slightly limit the increase in emergency admissions: "we found a lower increase in emergency admissions for the pioneers than the non-pioneers".

Any such relief must be welcome, but the study points out a problem in generalising from this experience:

"…it is not possible to identify precisely which elements of the programme, if any, led to any differential change observed (since the pioneers were not working from an agreed template)"

The researchers also warn that:

"1. The effect appears to be temporary: and as such the effect may have been linked to changes that took place in the early stages of the pioneers or pre-pioneer but were not sustained; or the non-pioneer areas introduced changes which have subsequently reduced the difference between them and the pioneers.

"2. The changes in emergency admissions were not shown in all places and even varied between local authority areas within the same pioneer."

Are we any wiser? Perhaps it underlines the importance of service working closely together: if this can read across to the need to avoid fragmented contracts and privatisation, the lesson could be a useful one. We may have to wait a while for such conclusions.

Two-tier system with subsidised private sector

Beware the Irish model of healthcare!

John Lister

A recent research paper on private health expenditure and the affordability of private financing of health care in Ireland warns us that "reliance on private health expenditure as a funding mechanism undermines the fundamental goals of equity and appropriate access within the health care system."

Another research paper puts it even more bluntly:

"Ireland 'is the only Western European country that does not offer universal coverage of primary care, with 60% of the population paying out of pocket on average €52 per GP visit and two thirds of the population paying up to €144 per month for drugs as well as paying for other primary care services."

An emergency room visit without a GP referral is €100, a night in a hospital is €80 (up to an annual cap of €800) and even for those who sign up for the drugs payment scheme drug costs can be up to €144 per month.

Ireland had "the second highest rate of unmet need for healthcare due to cost, distance or waiting lists among EU countries in 2014," and the research shows an increasing incidence of "unaffordable private health spending" on user fees and private health insurance as patients seek to avoid long delays.

The origin of Ireland's two-tier system goes back to 1946. In Britain, Aneurin Bevan won his battle with the Tories and the BMA to push through the legislation to establish Britain's NHS: but in Ireland a popular but much less ambitious plan of free healthcare for mothers and children under 16 years was blocked by the power of the bishops and the conservative medical profession.

Eleven years later, as Irish journalist Maebh Ní Fhallúin recounts "the government established the VHI [voluntary health insurance] in its current form, a subsidised semi-state company that provided health insurance to those who could afford it. This policy decision resulted in the creation of a two-tier health system and remains in place today."

Impediment

VHI, covering 45% of the population and entrenching a 2-tier system, is now seen as a critical impediment to the implementation of a system of universal healthcare.

This is the hidden reality behind the Irish government's assurances that "Ireland has a comprehensive, government funded public healthcare system."

Ireland's Health Service Executive itself goes on to say that: "Over 30% of people in Ireland have medical cards. Medical Cards allow people to get a wide range of health services and medicines free of charge. … People without medical cards can still access a wide range of community and hospital health services, either free of charge or at reduced cost."

More accurately, researchers sum up:

"Ireland's two tier health care system means that although everyone can access the public health system, PHI [private health insurance] allows people to gain preferential access to elective care in both public and private hospitals and diagnostic tests. Ireland does not have universal coverage for primary care and access and associated charges for services in the public system are determined by an individual's circumstances."

The problem has been getting worse:

"During the period of the financial crisis many countries in the EU, including Ireland, shifted the burden of health care financing onto private sources. In Ireland nearly €500 million of the cost of some aspects of healthcare was transferred from the State onto people between 2008 and 2014. Consequently, the proportion of total funding coming from private health expenditure increased from 21% in 2008 to 30% by 2015."

This two tier arrangement, in which a massively under-funded public sector is combined with the VHI scheme that should serve as a warning for what could happen to our NHS

Irishisation threat to NHS

It is this two tier arrangement, in which a massively under-funded public sector is combined with the VHI scheme that should serve as a warning for what could happen to our NHS if current trends continue: it is the Irishisation of the NHS rather than Americanisation that seems a more likely threat.

As in the USA, Irish medical costs have been outpacing inflation – increasing six times faster – pushing up VHI premium payments by 6% this year. But at the same time public sector spending is being reined in, and the gaps in care and delays in treatment in the public hospitals are becoming a scandal.

The Irish Cancer Society has warned that cancer patients can face extra costs of up to €1,200 per month for drugs and hospital visits – "everything from chemotherapy appointments to anti-nausea medication and hospital parking charges."

University Hospital Limerick had a record 81 patients waiting on trolleys for emergency care in mid-September, and there are many signs the under-funded public system cannot cope.

As in Britain and elsewhere, the private sector largely avoids providing emergency or urgent care, which makes up most of the caseload of public hospitals; nor do private hospitals provide integrated rehabilitation for patients needing multi-disciplinary care.

So, as in England, "Most patients admitted as in-patients to public hospitals are not suitable for care in a private hospital, including most patients admitted via A&E. That is why there are patients with top level health insurance on trolleys in public A&E departments while there are beds empty in nearby private facilities."

The problem is that while up to 20% of Irish public sector hospital beds can at present be used for private patients, in practice far more are taken up, with up to 50% of all patients in public hospitals having private insurance.

Beds are in short supply, despite growing population: numbers fell during the financial crisis, and it's now estimated that up to 15,000 more acute beds are needed above the current 12,000. Public hospitals are running at 110% occupancy.

As in England, academics claim that an expansion

of nursing home places could relieve the pressure on hospitals, but this is not costed, and there is no plan to make this happen.

To make matters worse, ministers have given tax breaks for private hospitals which have encouraged a further growth in that sector – to the detriment of public hospitals, not least in the diversion of scarce specialist doctors. As the Irish Times pointed out back in 2003:

"This State encouragement of private medicine has been grafted on to a system in which private hospitals are primarily staffed by hospital consultants on public salaries. Of the 790 consultants staffing private hospitals and clinics in January, 75 per cent held public contracts."

Even though Fine Gael plans to switch to a Dutch-style insurance-based model were dropped on cost grounds in 2015, the contradictions of the two-tier system remain unresolved. It falls short of the access to universal health care which governments around the world in 2015 committed themselves to work for in the UN's Sustainable Development Goals (SDGs).

Tens of thousands of nurses, members of the Irish Nurses and Midwives Organisation INMO and the Psychiatric Nurses Union staged a series of strikes at the beginning of the year demanding increased pay and action to ensure safe staffing levels in crowded hospitals.

Sláintecare report

As a result in May 2017, an Irish cross-party parliamentary committee published proposals for ambitious reform, known as 'Sláintecare' – the first time there has been a cross-party political consensus on major health reform in Ireland.

But the consensus seems to have been short-lived. No minister was present at the end of August to launch a much delayed follow-up report. It was released with minimum publicity. It exposes institutionalised inequalities in access, funding and provision of care – and controversially proposes to remove private work from public hospitals within five years.

The income to hospitals for this work is estimated at €650m per year, and the proposal has triggered questions over the financial and practical implications of implementing the change, as well as predictable angry responses from some top medics, who are resisting any change to their contracts that might limit their private work.

One argued in Business Post: "The middle-class 'socialists' extolling a public-only system won't be seen for love or their insurance money in these hospitals. Public hospitals will become places where few will want to work. Hospital doctors, nurses and therapists are already shunning what were once highly sought-after positions in the public system for jobs in private hospitals."

Higher pay in private sector

Some of the doctors have plenty to lose. Many have been drawn to the much higher pay in the private sector: doctors working full-time in the private sector can expect to earn anywhere from €280,000 to €1 million: by contrast those in the public system hired since 2012 are typically paid between €112,000 (if they are allowed to work off-site) and a maximum of €165,000 (public-only work).

Cancer campaigners in 2015 highlighting costs of treatment

The Sláintecare reforms could increase this to €182,000, but still fall short of private sector levels.

But the problems aren't restricted to the hospital sector; there has also been a process of corporatisation of primary care through the injection of private capital into the development of primary care centres (PCCs), and private firms' increasing influence over general practice through partnerships with doctors.

About 55 per cent of Ireland's PCC premises are leased by the HSE from private landlords, and 10 per cent are (PFI-style) PPP projects: just 35 per cent of them remain in public ownership. American, Australian and British capital is involved in this market as well as Irish companies.

A recent overview in Business Post notes that:

"Critics of corporate ownership in general practice say it drives up referral rates, lengthens waiting lists, reduces investment in the practice, breaks continuity of care and erodes accountability by diminishing GPs' control."

While the future of Irish healthcare, and the commitment of the government to its own reforms remain uncertain, the harsh inequalities, financial costs and gaps in the Republic's flawed two-tier health system continue.

They are one reason why the voting public in Northern Ireland might fear growing links with the Republic – as well as a stark warning as to what could become of England's NHS if the chronic under-funding is not reversed.

The report exposes inequalities in access, funding and provision of care – and controversially proposes to remove private work from public hospitals within five years.

As another winter approaches …

What's happening to our A&Es?

As autumn sets in and winter looms there are already worrying signs of another year's winter pressures on the NHS, and a reminder of the extent of the decline that has taken place since 2010. JOHN LISTER reports.

NHS England figures show a staggering increase of 1,400% in the numbers of so-called "trolley waits" from August 2010 to August 2019.

Other NHS figures show 12 hour waits for a bed after a decision to admit a patient have increased 372-fold from just 1 in August 2010 to 372 in April 2019

Perhaps even more alarming is the big increase in pressure on emergency services across the summer months which used to be relatively quiet.

In July 2019 there were 57,694 patients waiting more than 4 hours from decision to admit to admission, 34.7% higher than July 2018. Of these, 436 patients waited more than 12 hours (192.6% higher than in July last year).

More shocking perhaps is that the increased delays flow from a combination of rising use of A&E with a hefty reduction in front-line beds and services outside hospital. Numbers of the most serious "Type 1" emergency patients attending A&E in August have increased by just 21% since 2010, while the population is estimated to have increased by around 5.6%.

More seriously ill

However the patients who arrive are more likely to be seriously ill and require a bed: numbers of Type 1 being admitted have increased by more than a third (34%) over the same period, with the proportion of patients being admitted increased from 25% to 30%.

Total emergency admissions to hospital, which include urgent referrals by GPs, have risen by 28%, and by a significantly higher rate than general attendances at A&E.

But while the numbers have been rising on all fronts, the numbers of front-line beds available to admit them to has been falling overall: there were 8,779 fewer "general and acute" beds available in quarter 1 of 2019-20 than there were in quarter 1 of 2010-11. The reduction of almost 8% has come from a system that for years has had fewer hospital beds per head of population that almost any comparable country.

But there has been an even sharper reduction in mental health bed numbers: back in April 2010 there were 23,515 mental health beds: by April 2019 there were just 18,271 – a reduction of over 5,000 beds, or 22%. The targets for mental health are all much less demanding than those for acute hospital care, but NHS Improvement notes that at the end of June 2019 there were 805 Out of Area Placements for mental health patients, of which 770 (96%) were "inappropriate" (resulting from a lack of local NHS beds available).

The squeeze on acute hospital beds has run alongside a chronic failure to hit performance targets for emergency care and elective treatment.

NHS Providers last month noted that while the government's target is to admit 95% of patients within four hours, A&E performance had been "sitting around the current 86.5% for the last 3 months:" the 95% target has not been achieved for four years.

NHS figures show 12 hour waits for a bed after a decision to admit a patient have increased 372-fold from just ONE in August 2010 to 372 in April 2019

4.5 million on waiting lists

The BMA notes that there are now 4.52 million people in England now waiting for treatment, with 14.2% waiting over 18 weeks.

NHS Providers also pointed out that the NHS is "missing the three key cancer targets – the 2 week wait, 31 day and 62 day."

The decline in performance in cancer care has been especially notable, since figures were first collected in 2016. Then 94.8% of suspected cancer patients were seeing a consultant within 2 weeks of an urgent referral by a GP: now just 90.9% are doing so, bringing anxious delays to 180,000 people last year.

The performance on urgent referrals for patients with breast symptoms but not initially suspected as cancer has plummeted from 96.1% seen within 2 weeks to 82.4% in July.

In June the Public Accounts Committee heard that one in five cancer patients is having to wait up to two months to begin hospital treatment.

July was the 43rd consecutive month that the government target - to treat 85% within two months - has been missed. More than two thirds (69.9%) of providers missed the target.

As the BMA has warned, these figures indicate more trouble looming as the temperatures drop:

"Given the lack of a recovery from winter, it looks likely that the upcoming winter will see unprecedented pressure on the NHS.

"This will result in longer waits, with staff and patients suffering the consequences unless the Government takes action."

THE lowdown

Health news, analysis and campaigns.
NUMBER 12, October 26 2019

Informing, alerting and empowering NHS staff and campaigners

Fresh bid to force repeal of Health and Social Care Act

Shadow Health Secretary Jonathan Ashworth broke with convention last week by challenging the Queen's Speech: he tabled an amendment regretting that it did not commit to repeal the Health and Social Care Act.

This was aimed at puncturing the Johnson government's efforts to portray thmselves as supporters of the NHS: but it was also a timely reminder that until it is repealed the Act remains the legal basis of the NHS.

Attempts by NHS England to get around the Act's limitations have led to the establishment of an increasing proliferation of undemocratic and unaccountable organisations with no legal powers or legitimate status, notably Sustainability and Transformation Partnerships and "Integrated Care Systems".

But there is little point in merely tinkering with details: the Act itself, the regulations attached to it, and the legislation it amended in the 2006 Act to create a competitive market in health care, all stand in the way of progress.

The repeal is needed to:

- reinstate and strengthen the responsibility of the Secretary of State to provide a comprehensive and universal health care system,
- end the focus on competition and the requirement on commissioning bodies to put services out to competitive tender,
- begin to unravel the contracts which have opened up mental health, community health, primary care and other clinical services as well as support services to private providers,
- and legislate to exclude the NHS and all its services from the provisions of the European Union's Public Procurement Directive and from the Public Contract Regulations 2015.

Attempts by NHS England to get around the Act's limitations have led to an increasing proliferation of undemocratic and unaccountable organisations

Only by legislating in this way to reverse the privatisation process of the last 20 years and reintegrate the NHS as a public service can we protect it from the impact of future trade deals with the US and other countries, and ensure patient data is used only for the improvement of health services and not sold off or exploited for commercial gain.

After a delay while Johnson attempted to steamrolller his 100-page Brexit bill through in a breakneck 3 days, Ashworth's challenge was debated on October 23, but the amendment was defeated – with the Lib Dems abstaining to give ministers an easy ride.

Fragmentation and broken promises - a look back at the Act that was pushed through by Tories and Lib Dems - p4-5

Compass strikers pay protest at Surrey HQ

The need to halt and reverse privatisation was underlined by the continued fight by support staff employed by contractor Compass at NHS trusts in St Helens and Blackpool.

They have taken 12 days of strike action, challenging the company's refusal to match NHS pay rates and working conditions.

On October 22 a coachload of striking Compass workers travelled to the company's Chertsey headquarters (see above) to urge their employer to pay them the same as their NHS colleagues.

Most Compass employees are on the minimum wage (£8.21 an hour), yet work alongside staff employed directly by the NHS, where the lowest hourly rate is £9.03. This difference of 82p an hour is worth around £1,500 a year.

IN THIS ISSUE

Saving our NHS: staff tell us the truth that ministers won't

Truth is a casualty in every election, but this time more than ever the NHS cannot afford for its situation to be misrepresented. It is in a hole, beleaguered by a decade of harmful health policy and it needs a clear escape plan that the public can support. PAUL EVANS explains.

Recently I heard a hospital medic speak about a colleague's experience as a junior doctor, on call, at night covering 5 wards, about 100 patients.

A male cancer patient was under treatment and doing well, the consultant had noticed an infection, picked up whilst he was undergoing chemotherapy and so a round of antibiotics was urgently prescribed.

The junior doctor saw the instruction but for whatever reason didn't tick the box for immediate treatment on the computer system.

Normally this would be picked up by the nursing staff, but on this occasion the ward was understaffed and by nurses who don't normally work on a specialist cancer ward.

This vital few hours delay meant that her patients condition worsened, he was transferred to intensive care but tragically he died a few hours later.

An avoidable death, a mistake by an over worked doctor, but also a failure of system working too close to the edge.

Country-wide problem

We know from multiple reports and surveys that a lack of staff is compromising care right across the NHS. The health watchdog (CQC) has found that 70% of hospital trusts in England are failing to meet national safety standards.

One junior doctor told the *Guardian* last year, "The youngest doctors in the hospital are given dangerous levels of responsibility; there is one newly qualified junior doctor to 400 patients on night shifts. The administration is in agreement, but confess there is not enough money to employ extra staff."

In a survey of NHS staff, which included nurses, doctors and managers 80% said they had raised concerns about unsafe staff levels. More than half said that no action had been taken.

NHS leaders say understaffing is their number one concern.

The health service is short of 100,000 staff - including 70,000 nurses and 7000 GPs, but analysts predict that this will rise to a deficit of 250,000 staff by 2020 if the NHS continues on the same trajectory.

Despite all the evidence and unified calls for action, the NHS still does not have a funding commitment that can boost its capacity, make it safer and push up the standards of care.

The staffing crisis has been fuelled by funding cuts of £2bn in the education and training of staff, since 2006. Overall health experts blame "an incoherent approach to workforce policy at a national level, poor workforce planning, restrictive immigration policies and inadequate funding for training places".

The *Interim NHS People Plan* – the new workforce strategy was only published by NHS England in June. Repeatedly delayed, it has finally arrived several years into the crisis. Despite receiving widespread approval for its dissection of the situation, it was not backed by any significant new money to bring about the sizeable uplift in staff training and recruitment that the NHS needs.

NHS leaders are frustrated, calling for a "funded, credible" workforce plan.

This month's *State of the NHS* report from NHS Providers concludes that "Current performance levels are the worst in a decade and trying to work NHS staff harder and harder is simply not sustainable"

Trade unions have been running long standing campaigns to introduce safe staffing levels and reintroduce the bursary for nursing students. Alongside the TUC, eight health unions are calling for a long-term commitment to properly fund the NHS - in line with the cost evidence presented to the government by the Institute for Fiscal Studies.

"Current performance levels are the worst in a decade and trying to work NHS staff harder and harder is simply not sustainable"

Nail the funding lie

Meanwhile ministers, without any shame tell us that the NHS has received "record investment" – presenting inadequate rises to an already insufficient budget as a reason for celebration.

In reality the NHS has suffered the longest and deepest period of underfunding in its history.

A 9-year funding squeeze has restricted the NHS to annual rises of 1.5% against rising costs of nearly 4% (2010-18).

Year by year the funding gap has grown. Trouble with balance sheets has inevitably translated into human suffering - cuts to services, understaffing, rationing, delays, compromised care and sometimes tragic failure.

Theresa May announced an extra £20bn over five years in 2018, which was recognised by economists as enough to keep the lights on (3.3% a year after inflation) but not the investment needed to improve standards (minimum of 4.1% per year).

In recent weeks Boris Johnson, keen to fix the Tories' slash and burn reputation has announced that he will spend an extra £1.8bn on upgrades for NHS hospitals, telling the BBC "I want to stress that this is new money".

Within a few hours an analysis by Sally Gainsbury, a policy analyst at the Nuffield trust, revealed that £1bn of the money was already in hospital accounts, as restricted savings. Mr Johnson was in effect just giving his permission to spend it.

The hyperbole around the building plans ballooned further out of control with Health Secretary Matt Hancock's extravagant claim to the Tory Party conference.

"Over the next decade we will build, not ten, not twenty, but forty new state of the art hospitals."

Alas again analysts exposed this exaggeration, but not before it was reported widely across the media.

Over the next 5 years the NHS will spend

an extra £3bn on capital projects, but the majority of the new money will go to just six trusts, each with hospitals in bad disrepair and whose projects are already in the pipeline.

A further 21 trusts will receive a small amount of seed-funding to "kick-start" their plans for the end of the next decade.

Cash strapped hospitals have built up a huge backlog of repairs estimated at £6bn. The Health Foundation predict that the NHS needs around £3bn every year for the next 5 years to get a grip on the problem.

Some areas of the NHS, like mental health and community services are getting a bigger uplift this year than the budget as a whole - as ministers will no doubt remind us, but only after several years of neglect and at a cost to other parts of the NHS as the overall size of the cake is just not bigger enough.

What does the NHS need?

Health economists agree that the government's funding pledges fall short because of one simple reality. They don't meet the inevitable and basic costs of the NHS: Growing numbers of older people, more chronic disease, new treatments and price inflation.

These are challenges which governments in many countries must confront. They mean that health budgets must rise by a minimum amount each year, just for standards to be maintained.

The NHS needs about 4% annual in terms just to meet current cost pressures and that's without raising the levels of care.

Ministers celebrated "the record investment" of an extra £20.5bn over five years and of course the NHS was relieved, but look at what it means year by year and the new level is still below the average annual increase that the NHS has received since it began, which is 3.7% (1948-2018).

The new NHS 10-year plan contains an ambitious wish list of improved care, which simply cannot be achieved without a realistic and long-term funding commitment which must be based upon the evidence about the costs the NHS faces.

Social Care and beyond

Of course, the pressures on the NHS are also linked strongly to the fate of other care services. Cuts to adult social care have reduced the number of people receiving these services by quarter. Health conditions are missed and left to worsen until finally people seek help from the ambulance services, GPs and their local A&E.

Emergency departments are often the place of last resort. Increasingly visible are the casualties of austerity; people who have become patients because of neglect, cuts to services and because they have no-where else to go.

Year by year the funding gap has grown. Trouble with balance sheets has inevitably translated into human suffering - cuts to services, understaffing, rationing, delays, compromised care and sometimes tragic failure

Listening to an A&E doctor speak at a public meeting recently, she described her most recent shift - a string of patients with complex needs:

An Elderly lady came in whose leg ulcers had become infected, because of neglect, she wasn't being cleaned properly.

She treated a young man with a deep wide cut on his face and he wouldn't say how he got it.

Two young women came in, one was a teenager and she had tried to commit suicide.

The other was an alcoholic and was getting withdrawal symptoms.

Two more of her patients were homeless.

The doctor pointed out that they all had access to healthcare but problems elsewhere in our society and in our care systems had led them to the NHS. The audience applauded loudly as she pointed out that we must do far more to address the causes of ill health - poverty, housing, family break up and addiction.

Policy questions

Almost 40 years ago the Black report concluded that health inequalities were due to many other social inequalities and recommended a wide strategy of social policy measures to combat the situation.

The report was rejected by the Secretary of State at the time and for decades ministers have been failing to confront the reality that these issues are connected and so must be our response.

So how does pressure on the NHS and its evident lack of capacity relate to the wider plans around the NHS? They are inextricably linked and we will be returning to this in Lowdown, as we do battle with our political leaders for an honest debate about what's happening in our NHS and what it needs to secure its future.

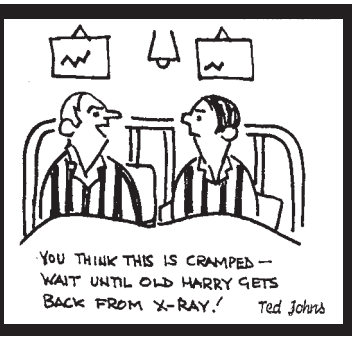
FACTS BEHIND A DECADE OF NEGLECT

Hospitals have built up a £6bn back log of repairs after their capital budgets have repeatedly been cut and the money used to cover running costs.

Key areas like public health are being cut - 25% less per head by 2020/21, when challenges like obesity related disease are costing the NHS over £6bn every year.

Despite recent announcements The NHS is enduring the biggest funding squeeze in its history – Over the decade average annual rises of 2.1% are too low to maintain standards. Economists agree that more than 4.1% a year is needed to improve them.

Social care spending has fallen by 5% in real terms since 2010/11. Even with recent increases, spending was around £1bn less than in 2010/11.



Why we need to scrap the Health & Social Care Act – and rescue our NHS

Many of today's campaigners have only dim memories – if that – of the Health and Social Care Act 2012 and how it was originally argued for by its author Andrew Lansley, and by leading Tory and Lib Dem politicians, in the teeth of opposition from almost every other party. So here JOHN LISTER looks back at the Act, the promises that were made and the grim results that show the need for its repeal.

The Health & Social Care Act (HSCA) 2012, which only affects England, was eventually pushed through parliament by the votes of Liberal Democrat MPs and peers supporting David Cameron's Conservatives.

The Bill's advocates made a series of misleading promises on how it would improve the NHS: instead, as its critics warned, it has made things worse. But now the HSCA is almost universally recognised to be not fit for purpose, with even NHS England pushing for parts of it to be repealed. Indeed the only argument against its repeal has been the claim that it would require another top-down reorganisation.

Six years of failure

The repeal of the 2012 Act is long overdue. Six long years since it came into force have proved beyond doubt that it cannot and will not deliver any of the promised benefits to patients or to NHS staff.

Government Fact Sheets explaining the basis for the Act in 2012 claimed it would deliver a number of improvements, among them:

"Clinically led commissioning; Provider regulation to support innovation; Greater voice for patients; New focus for public health; Greater accountability locally and nationally; Improved quality; Tackle inequalities; Promote integration; Choice and competition"

With the exception of competition, none of these has been delivered.

The promise that CCGs would be led by GPs, and that commissioning would therefore be "clinically led" was discredited before the CCGs had even been established in 2013: only a tiny handful of GPs, steered by management consultants, have ever involved themselves with CCGs. Far from being "clinically led" even the King's Fund in 2016 admitted that "financial pressures mean CCGs are frequently required to take tough prioritisation decisions," and others flow from the requirement to put services out to tender.

The "changes to provider regulation" were focused not on innovation but on scrapping the cap on the level of income foundation trusts could make from private medicine and commercial contracts. Amendments to the Bill resulted in the Act lifting the limit to less than half the FT's income – commonly interpreted as 49%.

There are around 1,140 beds in NHS private patient units in 90 hospitals: they generate income of £600m a year, although there are no published figures on how much these services cost to provide. Some major London foundation trusts such as the Royal Marsden make as much as 36% of income from private patients, but with no evidence that this benefits NHS patients.

By contrast the NHS has increased spending on sending patients for treatment in private hospitals to £1.8 billion a year – not least because of the lack of capacity after closure of 8,800 general and acute beds as a result of austerity funding since 2010.

The "greater voice of patients" and the commitment to "no decision about me without me" was an empty promise from the beginning, since CCGs have from the outset been at least as insensitive to public views and resistant to public consultation as previous PCTs and health authorities.

The problem is set to worsen as CCGs – with little or no consultation – merge into ever larger and more remote bodies, some of which aim to cover 2 million people.

Public health services have been run down, sidelined and even privatised by local and national government since the HSC Act, with year on year real terms cuts in central government funding running alongside the 40%-plus cutbacks in local government funding since 2010.

Since the 2012 Act there has been significantly LESS accountability locally and nationally, with increasing levels of contracting out of services on contracts jealously guarded as commercial secrets.

At national level NHS England is even now driving through a top-down reorganisation and outsourcing of imaging and pathology services with no proper local consultation, and ignoring local voices challenging their decisions.

Since the 2012 Act there has been significantly LESS account-ability locally and nationally, with increasing levels of contracting out of services

Far from offering improved quality of services, the Act has done nothing to prevent a massive all-round drop in performance against previous targets – with increased waiting times for emergency and elective hospital care, 4.3 million on rising waiting lists, long delays to access mental health care, growing delays in primary care appointments, and missed targets for swift treatment of cancer.

Health inequalities, which the Act was supposed to address have widened to extreme levels with a 16 year gap in healthy life expectancy between the wealthiest and most deprived areas, greater than the difference between the UK and Sudan.

Growing lists of treatments of supposedly "low clinical value" – including hip replacements and cataract surgery are being excluded by CCGs and NHS trusts, creating a

2-tier system in which only those wealthy enough to pay privately can access the care they need.

The empty promise that the Act would "promote integration" has been comprehensively discredited by the succession of measures subsequently taken by NHS England to sidestep the law in order to "integrate" services. Local government remains an under-funded and largely ignored subordinate "partner". And within the NHS itself the Act has served to DIS-integrate services as CCGs, obeying its regulations, have carved services up into contracts and put out to tender.

At the core of the Act was the promise of "choice and competition": but too many patients have seen their choice of local access to services overridden by cash-driven cuts and reconfiguration of trusts.

Meanwhile there is no evidence at all that competition has served to improve health services. This was clearly the view of the all-party Commons Health Committee in June this year, which noted that: "Competition rules add costs and complexities, without corresponding benefits for patients and taxpayers in return."

Indeed the disadvantages of a regime of contracting and competition arise whether or not the contract is awarded to a private bidder. Carving up services into thousands of separate contracts, and subjecting them to competition tends to force cost cutting and reduce the quality of care even if an NHS provider wins: and it also disintegrates services by awarding contracts to non-local providers.

However there have been numerous contract failures by private companies that have gone bust or abandoned contracts leaving patients and the NHS in the lurch: there have been no compensating benefits.

The record speaks for itself. The 2012 Act has dislocated and undermined services, reduced accountability to local communities, ignored patients' needs and concerns, further fragmented the NHS, obstructed efforts to secure collaboration between providers and between commissioners and providers, and opened up the danger of the £115 billion NHS budget being opened up to US and other corporations in future trade deals.

Anyone with any informed view has come to the conclusion that competition, contracting and market mechanisms have no benefit for health care systems and are an expensive encumbrance.

So the onus is on anyone who wants to keep this discredited and disreputable law in place to show what benefits it might offer to patients or hard-pressed NHS staff.

Campaigning postcard against the Act (2012)

'Not now' says the King's Fund: but when would change be right?

John Lister

King's Fund boss Richard Murray has continued in the inglorious steps of his predecessors in tail-ending government policy and rejecting any real challenge to the status quo, urging Labour not to press for a repeal of the Health & Social Care Act which the Fund itself conceded back in 2015 was "damaging".

Murray's defeatist blog argues that now is "not the right time" to deal with the legislation that has fragmented the NHS into thousands of contracts and privatised sections of it: "It is unwise to begin a re-fit of the NHS ocean liner in the midst of a hurricane."

So what could be the right time for bold action? How long does the King's Fund think it is right for the NHS to follow down a "damaging" path rather than attempt to secure a sound basis for longer term progress?

If it's not right to change course when the NHS is failing on so many targets, short of over 100,000 staff, deep in deficit and beset by crumbling buildings and clapped out equipment, when would it be right?

Murray's blog also ignores the potential imminent danger of the NHS being thrown into post-Brexit trade deals.

"Give it to us straight. How long have we got?"

Disruptive

He asserts it would be 'disruptive' for the NHS to face a new reorganisation: but few of the most important changes would disrupt the work of front line staff at all.

Five key issues must be addressed:

1. Restoring and clearly stating the duty of the Secretary of State to provide a comprehensive and universal health service.

This is not at all disruptive for front line staff, and can easily be achieved by legislation

2. Revoking and repealing all the regulations, clauses and sections of the 2012 Act that require local commissioners to put clinical and other services out to tender and made the NHS subject to competition law.

This is not controversial or disruptive. It reduces existing levels of disruption and disintegration, reassures NHS staff that they will not be forcibly transferred to a new employer, and reassures local people that services will be secure.

3. Beginning the process of rolling back the outsourcing and privatisation that has taken place, to reinstate a **publicly provided** NHS, in which all future services are governed by service level agreements rather than contracts and clearly excluded from public procurement regulations.

Contract failures

The case for this has been made by the repeated and widespread failures of private contracts: many managers will welcome it. Where it has been done, most notably in Wales, it has been shown to have beneficial impact on the quality of services and morale of staff.

4. Ending Foundation Trust status would **nullify the provisions of the Act** that encourage Foundation Trusts to generate increasing shares of their income from private medicine and private commercial activity.

This is disruptive only in the handful of FTs that have already expanded their private beds and services.

5. Establishing new, unified NHS bodies at local level that will bring together purchasers and providers in a single, publicly accountable NHS body. This will end the costly, wasteful and divisive purchaser/provider split instituted by Margaret Thatcher and entrenched by subsequent government "reforms" despite the lack of any evidence it has improved services or benefited patients.

This is also the area in which the 2012 Act created the greatest dislocation, with the scrapping of PCTs and establishment of CCGs.

However NHS England's Long Term Plan is already proposing to bring CCGs and trusts into so-called 'Integrated Care Systems': the disruption is already happening.

Under the current Act these bodies lack any democratic accountability or legal status: and without the changes listed above could be a step towards further privatisation.

New legislation is vital to ensure that integration is a process of rebuilding our NHS as a public service, publicly funded, provided and accountable.

Spike in heart attacks, asthma attacks and strokes on high air pollution days

New data shows that high air pollution days lead to a spike in the number of children and adults experiencing heart attacks or being sent to hospitals for strokes or severe asthma attacks. SYLVIA DAVIDSON reports.

King's College London, in conjunction with UK100, a network of local council leaders, has reported data for nine English cities which show that high air pollution days trigger an additional 124 out-of hospital cardiac arrests, 231 hospitalisations for stroke and 193 children and adults hospitalised for asthma.

The data was released to coincide with the International Clean Air Summit, held Wednesday 23 October by London mayor, Sadiq Khan and UK100, a network of local government leaders across England that have pledged to shift wholly to clean energy by 2050, with the World Health Organisation Director General, Tedros Adhanom.

Broken down, the data for the nine cities is as follows: London had 338 more emergencies a year on high pollution days compared with low pollution days, Birmingham (65 a year), Manchester (34), Liverpool (28), Bristol (22), Nottingham (19), Derby (16), Southampton (16) and Oxford (10).

Dr Heather Walton, Senior Lecturer in Environmental Health from King's College said: "The impact of air pollution on our health has been crucial in justifying air pollution reduction policies for some time, and mostly concentrates on effects connected to life-expectancy. However, health studies show clear links with a much wider range of health effects."

Previous studies have found a link between high air pollution days and a spike in visits to A&E and GPs and on life-expectancy, but this new data gives very precise figures for individual cities.

The data is a subset of material that will be published in an upcoming report, Personalising The Health Impacts of Air Pollution, due out in November 2019.

Deaths from pollution

Data from King's College published in 2018 by the government's Committee on the Medical Effects of Air Pollutants (COMEAP) estimated that between 28,000 and 36,000 people die as a result of air pollution every year in the UK. This is a significant increase on their 2015 figure of about 29,000.

The case of Ella Kissi-Debrah who died at the age of nine from severe asthma, highlights the consequences of not tackling air pollution. Ella lived near the South Circular Road in Lewisham, London, a hot spot for high air pollution. Ella had seizures for three years and 27 visits to hospital for asthma attacks until a fatal attack in 2013.

An inquest into her death in 2014 made no mention of air pollution as the cause of death, but her family always considered high air pollution episodes to have played a major role. In a report for the family presented to the attorney general in 2018, Professor Stephen Holgate, an expert on air pollution, suggested Ella might have survived if the air pollution around her home had not been so high.

In the UK, the government has consistently failed to take significant action on air pollution

As a result, the family's (the Ella Roberta Family Foundation) campaign for a second inquest was successful; in May 2019, the high court granted a new inquest into Ella's death. To date, no individual death has been linked directly to air pollution but if Ella's death is linked it would increase the pressure on the government to tackle the problem.

Despite the large body of evidence for its detrimental effects on health and life-span, the UK government and those across Europe have made little headway in tackling air pollution.

Failure of governments

In the UK, the government has consistently failed to take significant action on air pollution.

The activist organisation, ClientEarth, has won three cases in the high court against the UK government over its failure to deal with illegal levels of nitrogen dioxide pollution and in May 2018 after the most recent court loss, the UK government was referred to Europe's highest court.

Proposals for tackling air pollution were laid out in the Queen's speech, but measures are considered by campaigners to be too vague and weak.

Polly Billington, the director of UK100, told the Guardian that they "would like to see World Health Organization air pollution standards included in the bill, as they are widely seen as gold standard, with a legally binding timetable to meet them, as that creates certainty and enables long-term planning."

Earlier this month, the European Environment Agency published its Air Quality in Europe 2019 report, which brings together 2017 data from monitoring stations across Europe. The conclusion is that little progress has been made on tackling air quality in Europe.

Following more than 10 years of gradual declines, the levels of the dangerous fine particulate matter known as PM2.5, which can lodge deep in the lungs and pass into the bloodstream, appear to have reached a plateau across Europe.

In the UK, the monitoring station at Marylebone Road continued to record the highest level of nitrogen dioxide pollution in western Europe, despite falls in the overall concentrations of the gas.

How I went private without realising

When Madeleine Dickens went to her doctor in Brighton about an increasingly troublesome bunion, she was surprised and pleased to get a quick appointment with a consultant, but what she hadn't reckoned on was finding her NHS care being delivered in the private sector.

Persistent foot pain in her right foot had first driven Madeleine to her GP, who was happy to refer her to a specialist. They didn't discuss who this would be, so on the day of her outpatient trip she was not expecting to walk through the doors of a plush private health clinic in Burgess Hill.

"I was surprised on both counts [a consultation and in a private clinic], but in particular to not be going to the podiatry clinic at the Brighton General."

Madeleine is a member of a local NHS campaign group, so is more aware than most about the use of private companies in the NHS and because of her objections would certainly have opted to stay within the NHS if she had been given a choice.

After a short examination of her foot, the consultant proposed an operation, another surprise as Madeleine thought that under NHS guidelines a patient has to be almost immobilised to qualify for an operation and she certainly was not.

Further puzzlement followed when the confirmation letter arrived: "Much to my astonishment the only hospital proposed was the Gatwick Spire which I knew was a private hospital."

Madeleine immediately phoned the contact on the letter to say she didn't want to travel to Gatwick and that she wanted to be treated by the NHS. The contact said all they could do was to transfer her back into the NHS.

This seemed odd as at no time previously had she opted 'out' of the NHS, so why was she having to transfer 'back into' the NHS?

Back of the queue

The transfer 'back into' the NHS turned out not to be as easy as suggested, as when she phoned the NHS trauma and orthopaedic department a few weeks later they had no record of her, nor had they any record of the consultant Madeleine saw in the private clinic.

So as a result of not wanting to be treated in the private sector, she had effectively been shifted right to the back of the queue.

Madeleine's experience throws up numerous questions - at what point did Madeleine 'leave' the NHS? Why was she never given a choice of where her operation would take place? Why had she been offered an operation that appeared to go against guidelines? Why had nobody heard of the consultant?

Madeleine has now heard from others with a similar experience. She has also taken her case up with the local CCG and has now been put back into the system and not at the end of the queue. The CCG has also admitted that things had gone wrong in her particular case.

In Brighton and Hove, foot conditions are dealt with through the Sussex MSK Partnership, which is made up of Here (also known as Care Unbound, an employee-owned limited company), Horder Healthcare (a charity), Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership NHS Foundation Trust (SPFT).

The transfer 'back into' the NHS turned out not to be as easy as suggested, as when she phoned the NHS trauma and orthopaedic department a few weeks later they had no record of her

The partnership operates as a not-for-profit organisation under contract to Sussex CCGs, including Brighton and Hove CCG. The contract covers taking patients from first referral from a GP or self-referral through the treatment process.

Community clinic

According to the partnership's website, referrals are assessed by clinicians, with the most likely next step an appointment at a local community clinic with one of several different types of clinicians, such as a consultant, nurse specialist, physiotherapist or podiatrist.

If an operation is considered to be the best option, then the operation could be carried out by NHS hospitals in SCFT or SPFT or private hospitals, including those owned by Spire and BMI.

The use of the private sector for operations within the MSK pathway has grown steadily since 2014, coincidentally the year the Sussex MSK Partnership was set up.

As a result of a freedom of information request by a group of campaigners in Brighton & Hove it is known that from 2013/14 to 2017/18 the proportion of NHS-funded hip operations conducted in private hospitals increased from 24.5% to 54.5% per year and for knee operations the figure was 26.2% (2013/14) to 57.8% (2017/18) per year

In addition, the FOI found that the private hospitals were paid per operation and used their own selection criteria to choose patients. Operations on feet are also dealt with under the same contracts.

These figures show that over just a few years use of the private sector has sky-rocketed and it has become normalised in the NHS.

In Madeleine's case (and perhaps many others) patients are no longer being given a choice of NHS or private, but just shunted through the pathway.

Many people wouldn't have noticed that they were going to a private clinic for an appointment, and even if they did are unlikely to complain in the same way as Madeleine.

We have to hope that if they do, they don't also wind up at the back of the queue.

Concerns over quality of CQC inspections

The Lowdown is publishing a slightly abridged letter sent to CQC chair Ian Trenholm by the Campaign to Save Mental Health Services, which is focused on the Norfolk and Suffolk NHS Foundation Trust, which covers Matt Hancock's West Suffolk constituency. We at *The Lowdown* agree that the concerns they raise about the conduct of the CQC need to be shared – and answers need to be demanded.

For more than five years, the mental health services provided by Norfolk and Suffolk NHS Foundation Trust (NSFT) have been substandard and unsafe. As you know, NSFT has been rated 'Inadequate' by Care Quality Commission (CQC) inspectors three times and placed into Special Measures twice, where the trust remains.
We believe that people have died as a result of NSFT's failings and that NSFT is mental health's equivalent of Mid Staffs.

Until recently, CQC was one of the few parts of the NHS 'system' which genuinely wanted to listen to, indeed sought out, the voices of patients, carers and staff: the very people who use, rely upon and provide NHS services. The CQC met with us and others during the inspection process and took our experiences seriously, which NSFT, NHS England and the CCGs did not. For this, which we believe resulted in balanced inspection reports, we are extremely grateful.

However, since the last inspection and the appointment of a new Chief Executive at NSFT who was previously an employee of CQC, which has been followed by the appointment of one of the new NSFT Chief Executive's closest friends and former colleagues as CQC Deputy Chief Inspector of Hospitals and Lead for Mental Health, we and others have witnessed a worrying change of approach from CQC.

Previously, CQC maintained a professional distance and remained largely silent, quite properly as a regulator, between inspections: now the CQC Team Leader publicly praises the NSFT management, even when the trust's performance has deteriorated rapidly, as empirical evidence and patient and carer experience clearly confirms. …

More worrying has been CQC's changing attitude to engagement with those with experience of using or providing NSFT's front line services, which Sir Robert Francis said was key to preventing future scandals such as Mid Staffs. …

Prior to every previous inspection, we and other stakeholder groups were invited to meet CQC in the inspection period, usually during the inspection itself.

During the last inspection period, for instance, about thirty of us met CQC staff at the Maid's Head Hotel in Norwich, with similar meetings held with others. These meetings were arranged by the CQC Inspection Manager, who, we believe, is sadly no longer involved in the inspection process at NSFT.

We expected similar opportunities to be heard before the inspection currently underway and the CQC Team Leader indicated on 16 September 2019 that there would be such opportunities. She explained that these meetings had not been arranged in advance as:

'There will be opportunity to speak. We are doing the inspections on an unannounced basis so we have not announced when for obvious reasons'.

So, imagine our surprise when the timing of these so-called 'unannounced inspections' became widely informally known to NSFT staff several weeks ago and when the dates of these so-called 'unannounced inspections' were announced to NSFT staff by the Chief Executive of NSFT and former adviser to CQC, in the week before the inspections in Suffolk and a further week before inspections began in Norfolk and, indeed, before we and other stakeholders were told. …

What about our promised 'opportunity to speak' that could not be arranged because of the 'unannounced inspections'?

Since the 'unannounced inspections' were announced, we have heard nothing and neither have any of the other stakeholders who made submissions to whom we have spoken.

…

We submitted a thirty page report to CQC in July 2019 but have received not even an acknowledgement, never mind any follow-up.

We have spoken to other stakeholders who made submissions and they have not received acknowledgements or follow-ups either.

Since the promise of 'opportunity to speak', CQC appears to have changed its mind. …

We and other stakeholders to whom we have spoken have been invited to not a single 'focus group'. We have heard about a very limited number of internal NSFT focus groups at which CQC has referred to NSFT directors on extremely familiar terms and those raising genuine and important issues have been allowed to be shouted

Trusted sources from within the 'system' tell us that the NHS's regulators (NHS England, NHS Improvement and CQC) do not want to hear, indeed refuse to listen to, 'bad news' about NSFT

down by NSFT 'supporters' but that is all. The claim that 'we always want to hear all views' appears at best disingenuous.

We also note that that at the end of every previous inspection, there has been a feedback meeting for stakeholders and the local NHS 'system'.

Unlike previous years, those who would have expected to attend such an event have heard nothing from CQC.

Trusted sources from within the 'system' tell us that the NHS's regulators (NHS England, NHS Improvement and CQC) do not want to hear, indeed refuse to listen to, 'bad news' about NSFT.

We find these reports deeply disturbing, again with echoes of Mid Staffs. We wish to put on record our belief that NSFT being released from Special Measures before the evidence says so, is dangerous and has happened before at NSFT, with disastrous consequences.

We believe that such a decision would be at odds with the submissions received by CQC about NSFT. We challenge CQC to publish the various submissions it has received for the public to judge.

If CQC is unwilling to publish voluntarily, please consider this a request under the Freedom of Information Act for disclosure of stakeholder (not individual) submissions received regarding NSFT.

With the greatest of regret, it appears that the NHS 'system', including CQC, has decided that the best way to solve the serious problems at NSFT is to ignore the evidence and experiences of patients, carers and staff, to pretend that there are no serious problems and to release NSFT from Special Measures, which now appears predetermined, even before the inspection is completed. Indeed, we have heard this is the case from several independent sources. This is a shameful and dangerous situation.

From having almost complete confidence in CQC's impartiality and integrity, we now have virtually none.

We look forward to a full and prompt written response to our concerns. In the interests of transparency, we will be publishing this email.

Yours sincerely, Committee of the Campaign to Save Mental Health Services in Norfolk and Suffolk

Soon after weak-kneed councillors on North Somerset Council's health overview and scrutiny panel (HOSP) bottled out of referring the overnight closure of WESTON Hospital's A&E to the Secretary of State, arguing it would not achieve anything, campaigners in CHELTENHAM have been celebrating after securing a commitment by Matt Hancock in the House of Commons that their local A&E will not close.

CCG mergers get the nod

TWENTY Clinical Commissioning Groups covering over 5 million people are to be merged into just three as a result of the latest rubber-stamping of merger plans by NHS England.

South West London, South East London and Kent will each have just a single commissioning body from next April, with little likelihood that local concerns within these large areas will make any impact on plans being pushed through from above.

It's also rumoured as we go to press that the merger plans in North Central London have been nodded through, leaving only North West and North East London delaying their plans till 2021.

While many CCGs themselves, created as they were by the 2012 Health and Social Care Act to implement the process of carving up and contracting out an increasing number of clinical services, have been far from perfect, the loss of any local statutory body, and the concentration of power at a more remote level is still a significant loss of local accountability.

In Kent there are a number of hurdles to be surmounted before the merger, including delivery of the financial recovery plan this year, clear plans for how the financial position of Kent and Medway will continue to improve – and a decision in December on whether to determine whether the four east Kent CCGs can be released from legal financial directions.

Nonetheless the HSJ quotes a statement from Kent CCG managing directors making extraordinary claims for the benefits of merging organisaions which few patients or members of the public will have heard of:

"We strongly believe that having a single CCG will improve the quality of life and quality of care for our patients, and will help people to live their best life.

"It will save time, money and effort, freeing up GP time to see patients."

No evidence has been offered to show how life will be improved, or indeed significant GP time "freed up" by the merger.

Nor is there any explanation of why it was necessary to carry through this long-term change without bothering to consult the public covered by the merging CCGs, despite NHS regulations requiring them to do so.

Interestingly, just after Matt Hancock rubber-stamped plans for the downgrade of Telford's Princess Royal Hospital and the centralisation of Shropshire's emergency services in Shrewsbury, NHS England rejected proposals to merge Shropshire CCG and Telford and Wrekin CCG.

Local GPs in the north west and in Staffordshire have also stood up for themselves – and rejected CCG merger plans.

Why even the Americans don't want the US health care system

Continued fears that the NHS might be opened up to profit-grasping US health corporations in a post-Brexit trade deal have only been reinforced by repeated unconvincing denials from PM Johnson and trade secretary Liz Truss. So it's a good time to check out on how the world's most costly and inefficient health care system is working in the US. JOHN LISTER picks up on three recent published research papers.

Whose 'Medical Loss'?

One of the most telling jargon terms that gives a real insight into the insurance industry-led system created by Obama's Affordable Care Act (ACA) is "Medical Loss Ratio". Its topsy-turvy logic from the point of view of the patient or insurance policy holder is summed up neatly by the campaigning doctors of Physicians for a National Health Program (PNHP):

"Paying for health care is a loss for insurers. They get to keep for their administrative costs and profits whatever they do not spend on health care."

Insurance companies have always resented paying out: and it seemed to Obama' team drafting up the ACA that it could score political points by appearing to limit the scope of insurers to scoop profits from premium payments. As the PNHP puts it:

"In crafting the Affordable Care Act our legislators surmised that they could limit the administrative waste and excess profits by requiring that at least 80 percent of premiums be used for health care for individual plans and 85 percent for small group plans – the medical loss ratio."

No cap on profit levels

But as another paper points out the cap applies to insurer profit ***margins***, but not ***levels:*** in other words the way around the limitation is simply to expand the total amount of spending (and premium income collected), with the guarantee that the insurers can make 15-20% margin on any larger sum.

"If you were an insurer, think of the opportunity this offers," argues PNHP. Instead of trying to rein in costs, the new objective is to increase them to raise the global sum – and all the while getting subscribers to fork out the increased cost:

"How do you pay out more in health benefits? Simple. Negotiate higher prices with physicians and hospitals.

What the (research) papers say

Maximize benefits covered. Authorize more care …. Avoid adjusting claims and avoid claim denials. Do not investigate over-utilization or frank health care fraud."

Once the global cost has been inflated **"Then have your actuaries calculate the premiums to include 15 to 20 percent over the inflated health care spending. Make that a little bit over 15 to 20 percent which will then have to be refunded but will ensure that the full padded margin is received."**

No impact on spending

This was swiftly demonstrated as the ACA took effect In 2015 researchers noted that "the ACA had no impact on insurance industry overhead spending".

Two years later another team pointed out the nonsense of the ACA approach: an insurer making an additional 1% of surplus above the permitted level has to bear the full administrative cost of keeping expenditures below 80%, but reaps none of the rewards. As a result, **"minimum MLR requirements encourage higher costs, not lower."**

More recent figures show the extent to which this cynical policy is being implemented by the big insurers, who have over-inflated their costs to the extent of owing £1.37 billion to nearly 9 million policy holders from 2018-19: more than half of this is in the market for individual insurance, where 3.7 million Americans are owed refunds of £769m. These are the highest rebates since the ACA was put in place.

A large share of this ($217m) is down to Centene, one of the US insurers to show some interest in the NHS, and which has focused on lower income subscribers. At the top end, Sentara/Optima, which had the highest individual premiums in the US, owes each subscriber more than $1,200.

But don't cry for the insurers: after they suffered a brief period of losses in 2016 the larger rebates are the result of the most profitable year for individual insurers since the ACA was introduced in 2010.

The big insurers have over-inflated their costs to the extent of owing £1.37 billion to nearly 9 million policy holders from 2018-19

Mean-spirited nonprofits

For many who remain uninsured or under-insured while the insurers laugh all the way to the bank, the answer can often be seeking treatment in one of the USA's 2,508 "non-profit" hospitals, including 56% of community hospitals.

These are exempted from paying most taxes and allowed to float tax-free bonds – in exchange for giving free or discounted care to patients who can't afford to pay.

The IRS leaves it up to each hospital to decide the qualifying criteria; between them non-profit hospitals provide roughly $14 billion of charity care a year – about 2% of their operating costs.

Now Kaiser Health News has highlighted widespread abuse of this status by "non-profit" hospitals that dodge their commitments.

One of them, St Joseph Medical Centre in Tacoma, Washington recently settled a lawsuit from the state attorney general alleging they erected barriers to charity care, and agreed to pay up more than $27m in refunds and debt forgiveness.

Documents disclosed in the lawsuit included advice to heath workers on how best to pressurise patients to pay up, while patients were not offered application forms for assistance.

KHN reports nearly half (45%) of all nonprofit organisations (running 1,651 hospitals) are "routinely sending medical bills to patients whose incomes are low enough to qualify for charity care, with an estimated total of $2.7 billion in bills to patients who would have qualified for assistance if they had filled out application forms.

Over half the bad debts being written off by nonprofit hospitals in St Louis, Pennsylvania, Virginia and Memphis are owed by patients who should have received free or subsidised care.

Bad debts are absorbed into hospital running costs and eventually increase the rates charged to private insurers.

The only losers in the process are the patients, forking out insurance premiums or fleeced for charges they should not have to pay.

Annual wastage of resources is estimated to be between $760bn and $935bn, equivalent to around a quarter of the $3.7 trillion spent on health

Measuring US wasted spending

The excess costs passed on to insurers falls into the general category of "wasted" spending, which has been widely seen as costing as much as a third of the already inflated level of US health spending.

Now a new study has attempted to update these 2012 estimates and to assess what compensating steps are being taken to contain or eliminate waste.

It focuses on the 6 waste domains previously identified by the Institute of Medicine and the 2012 paper: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse, and administrative complexity.

Up to $935bn of waste

It now estimates annual wastage of resources on services other than paediatric care (for which there are no data available) to be between **$760bn** and **$935bn**, equivalent to around 25% of the $3.7 trillion spent on health: this might appear to be a step forward from the previous higher estimates, but they are still only estimates, and the sums of money involved are eye-watering:

Annual savings (with no schemes identified to address the problem of administrative complexity) are estimated to yield potential totals between $191bn and $282bn annually – equivalent to around 25% of the actual wasted money.

It's not clear how much of the "potential" savings are realistically likely to be achieved, or over what time frame: the system is so fragmented with so many perverse incentives it is hard to implement any coherent policy and – as we have seen above – there is little incentive for insurers to do so.

But even if they were achieved, it would still leave the US medical industrial complex squandering well over half a trillion dollars each year, and up to £653bn, in wasted spending.

Administrative complexity alone swallows up the equivalent of £205 billion – more than the entire NHS and social care budget each year, year – but delivering no benefit to anyone but corporate fat cats..

US annual bill for waste

Failure of care delivery,	$102.4 bn to $165.7 bn;
Failure of care coordination,	$27.2 bn to $78.2 bn;
Overtreatment/ low-value care,	$75.7 bn to $101.2 b;
Pricing failure,	$230.7 bn to $240.5 bn;
Fraud and abuse,	$58.5 bn to $83.9 bn;
Administrative complexity,	$265.6 billion

THE lowdown

Health news, analysis and campaigns.
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Informing, alerting and empowering NHS staff and campaigners

Fifth time around! Election pledge recycles old promise of more GPs

Weary GPs have heard it all before – FIVE TIMES!

The Conservative Party has once again pledged to increase recruitment of GPs, and to create "50 million more GP appointments a year".

This time the promise is for **6,000** new doctors to general practice by 2024/25, **half of them** fully qualified GPs along with **3,000 trainees**, who would be spending longer training in general practice that they do currently.

Round 1 2015

The problem is that this is a variation of the same old promise that has been wheeled out time and again with ever-diminishing credibility since 2015 when Jeremy Hunt first promised 5,000 extra full time equivalent (FTE) GPs by 2020. That was four years ago, during the election campaign.

By the end of June 2015 Hunt was already "softening" his promise and admitting it was the highest achievable increase. But three months later he was at it again, promising an extra 5,000 GPs by 2021.

Round 2 2016

Recruiting an extra 5,000 GPs from home and abroad was also set out as an objective early in 2016 by NHS England in the GP Forward View.

Round 3 2017

Early in 2017 Hunt made the job of GPs even more onerous and unattractive by requiring them to record patients' migration status. He also claimed that the purported £500m extra revenue from charging overseas patients for treatment could help pay for the anticipated 5,000 extra GPs (see inside page X).

Neither the revenue nor the GPs have materialised.

By May 2017 even the King's Fund was questioning the credibility of Hunt's promise, pointing out: "In 2016, there were 34,495 full-time equivalent GPs (including locum doctors).

"Rather than an increase, this represented a fall of 96 GPs, or 0.3 per cent of the GP workforce, compared with the previous year."

"The losses again highlight the spectacular failure of the Government's pledge to hire 5,000 extra GPs between by 2020."

***Daily Mail*, August 2019**

Round 4 2018

In June 2018 official workforce figures revealed that the NHS had actually lost 1,000 GPs since September 2015, when Hunt first pledged at least 10,000 extra primary care staff, including 5,000 GPs, within five years. GP magazine *Pulse* revealed NHS England's campaign to recruit GPs from overseas had signed up just 85 doctors.

Hunt confessed that he was 'struggling to deliver', admitting that 'it has been harder than we thought'.

By October 2018 Matt Hancock, Hunt's successor as Health Secretary, had abandoned the 2021 deadline, but reiterated the commitment to increase GP numbers by 5,000: **by then the FTE GP workforce had sunk to more than 1,400 below the level when Hunt's target was set.**

In November Hancock was embarrassingly forced to delete claims of a "terrific" increase of 1,000 GPs joining the NHS in just three months, after being **censured by the government statistics watchdog the UKSA**. Hancock was counting trainees as GPs: numbers of qualified GPs had had actually fallen by 674 over 12 months.

Round 5 2019

By August even the *Daily Mail* was pointing to the scale of failure:

"The NHS has lost almost 600 GPs in the last year as its recruitment crisis continues, figures show. "Almost as many family doctors left the health service between June 2018 and June 2019 as did in the entire three years to March. …

"The losses again highlight the spectacular failure of the Government's pledge to hire 5,000 extra GPs between by 2020."

Now in November a similar promise is being made again. Would anyone bet on this being delivered?

IN THIS FIRST PRE-ELECTION ISSUE

Don't hold your breath waiting for all £130m of repairs to be done

Hospitals crumble as ministers rattle out empty promises

John Lister

NHS Providers, the body representing trusts, has been campaigning for sustained increases capital funding for several years. Their CEO Chris Hopson argues that: "Over the last five years we've had to transfer nearly £5bn [of capital funding] to prop up day to day spending.

"As a result, the NHS now has a maintenance backlog of £6bn, £3bn of it safety critical. The NHS estate is crumbling and the new NHS long term plan can't be delivered because we don't have the modern equipment the NHS needs."

Warning

An NHS Providers briefing document in August warned:

"The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year)."

Our Lowdown table (left) draws on the recently published 2018-19 Estates Return Information Collection (Eric) statistics from NHS England. These show some of the latest figures on the scale of bills for backlog maintenance facing trusts around the country.

We have listed the trusts with combined bills of over £20m: they add up to almost £5 billion.

Most of these trusts are not on any government list for extra funding, and are set to receive no support as their buildings fall apart and equipment fails. The Conservative Party conference announcement equates to around £600m extra a year, well short of the additional £2bn that experts and health trusts say is needed. And £2.7 billion to build new hospitals will affect at most six trusts – leaving the others to cope as best they can.

The backlog total of £6.6 billion is 60% higher than it was five years ago.

Over half the backlog is to address 'high' and 'significant' risk, which has increased from 34% of the total in 2013 to 53% last year.

Between 2017/18 and 2018/19 there was a 25% increase in clinical service incidents arising from estates and infrastructure failure.

The results of a freedom of information request to all hospital trusts in England by the Labour Party in July 2019 revealed at least 76 hospital trusts in England suffered incidents caused by "estates and infrastructure failures" in 2018/19.

Many involved sewage, including sewage coming through the floor on the ultrasound corridor of one trust in Yorkshire and the Humber. Other incidents included leaks of wastewater and water into hospital wards, sewage coming up through the bathroom drains, broken lifts, inadequate heating systems, water running down walls and broken scanners.

In July 2019 fire chiefs threatened to close down parts of four hospitals as they were so rundown they had become a hazard to patients and staff.

Theatres

The recent scandalous state of operating theatres in Oxford University Hospitals Trust's once prestigious John Radcliffe Hospital underlines the scale and impact of this neglect. The Care Quality Commission has taken urgent enforcement action.

According to the Health Foundation the capital budget for hospital infrastructure has fallen in real terms over the last eight years, with NHS trusts in England seeing a 21% reduction in capital funding.

In 2010/11, capital spending by the DHSC was £5.8 billion, but by 2017/18 this had fallen in real terms to £5.3 billion, a fall of 7%. Joshua Kraindler, economics analyst at the Health Foundation, warns that:

"The capital budget is, in real terms, the same as it was in 2010-11 and as a result, capital investment per NHS worker continues to fall."

Trust	Combined backlog deficit (£m)
Imperial College Healthcare	691.1
London North West Healthcare	216.5
Barts Health	199.6
Oxford University Hospitals FT	140.5
Nottingham University Hospitals FT	130.7
Sheffield Teaching Hospitals FT	127.6
Pennine Acute Hospitals	124.5
University Hospitals Birmingham FT	118.0
Newcastle upon Tyne Hospitals FT	114.8
Leeds Teaching Hospitals	109.1
Hillingdon Hospitals FT	107.4
Cambridge University Hospitals FT	103.9
St Georges University Hospitals FT	99.2
East Sussex Healthcare	96.9
Epsom & St Helier University Hospitals	96.1
Sandwell and West Birmingham	91.7
University Hospitals of Leicester	88.6
United Lincolnshire Hospitals	82.9
Hull and East Yorkshire Hospitals	81.0
Doncaster & Bassetlaw TH FT	73.6
Calderdale and Huddersfield FT	73.1
Hampshire Hospitals FT	72.8
Buckinghamshre Healthcare	71.4
East Kent Hospitals University FT	69.3
West Hertfordshire Hospitals	68.5
University Hospitals Morcambe Bay FT	68.2
University Hospital Southampton FT	67.0
Medway FT	62.6
Gloucestershire Hospitals FT	59.0
Shrewsbury & Telford Hospital	57.8
Mid Yorkshire Hospitals	56.9
Manchester University FT	51.7
Mid Cheshire Hospitals FT	49.0
Royal Liverpool & Broadgreen	48.5
Princess Alexandra Hospital	48.4
Royal Berkshire FT	48.3
Birmingham Women & Children's FT	47.7
Royal Free London FT	47.5
South London & Maudsley FT	46.1
Royal United Hospitals Bath FT	44.8
Stockport FT	42.7
University Hospitals Plymouth	42.0
Salisbury FT	41.3
Kettering General Hospital FT	40.7
King's College Hospital FT	39.9
North Tees and Hartlepool FT	39.9
Poole Hospital FT	36.5
Wirral University Teaching Hospital FT	36.3
Lewisham & Greenwich	36.2
Northumbria Healthcare FT	35.4
Kingston Hospital FT	35.3
Lancashire Teaching Hospitals FT	35.1
Luton & Dunstable UH FT	33.9
Torbay and S Devon Health Care FT	33.4
Great Ormond St Hospital FT	33.1
Royal Cornwall Hospitals	32.4
Croydon Health Services	31.5
Taunton & Somerset FT	29.1
South West London & St Georges	28.8
Aintree University Hospital FT	28.4
Northampton General Hospital	28.3
East and North Hertfordshire	25.3
West Suffolk FT	25.0
University Hospitals Bristol FT	23.5
Bolton FT	23.2
Salford Royal FT	22.1
Walsall Healthcare	21.2
Airedale FT	20.0
Total (68 trusts above £20m backlog)	**4,952.80**

Trusts bid to gag NHS staff

Boris Johnson may be keen to be photographed with NHS staff – but he doesn't want to hear their concerns.

In fact the GMB union warns NHS bosses are trying to 'gag' staff during the general election.

A letter has been sent to workers from Ambulance and NHS Trusts across the country warning NHS employees they must not take part in "debates, activities and events that may be politically controversial."

Rachel Harrison, GMB National Officer, said:

"Our health service is at breaking point thanks to years of Tory mistreatment. Now staff are being told they can't talk about it in case it's politically sensitive.

"They must be allowed to be heard."

Government's "half price visa" scam won't solve staffing crisis

After repeated scandals in which overseas doctors have faced deportation or been blocked from entering the country by Home Office visa blunders, ministers have combined to shoot themselves in the foot with their latest proposal to fractionally lower the barriers to overseas staff coming to work in the NHS.

Their plans for a new "NHS visa" aimed at making it quicker, easier and cheaper for foreign professionals to take NHS jobs in the UK have been roundly ridiculed and condemned as "immoral" and "heartless" by the Royal College of Nursing, and branded as a new "nurse tax" by the LibDems.

The new visas, which appear to be opposed by NHS employers, are part of a new 'points-based immigration system' which will form an updated "hostile environment" if the Conservatives are re-elected.

Overseas health professionals would be guaranteed decision within two weeks – one week faster than the present system.

But while the costs of making an application would be 'halved' from £928 to £464, any staff coming to Britain would face the 'health immigration surcharge' of £400 a year: **so the total cost is not halved, but cut by a third.**

And as a triumphant expression of short-sighted thinking the visa and charges would also be extended to EU nurses (currently exempt) when the UK leaves the European Union.

Matt Hancock, claimed the new visa would make it "easier for us to hire the finest doctors and nurses from other nations to come and work in the NHS".

But of course it would be easiest if potential recruits did not face racist fees and charges at all.

Wilfully misleading:

Claims of £33.9bn extra spending inflate value by 65%

John Lister

Every year since the NHS was founded spending has gone up in cash terms to cope with rising costs and population.

So technically EVERY year has been the "highest-ever".

But the issue that matters to the NHS is the value of the money – what can it buy in staff and services?

If spending is falling behind inflation and cost pressures – as it has each year since 2010 – to simply quote the cash value is wilfully deceptive.

Back in the summer of 2018, to mark the 70th birthday of the NHS, Theresa May announced that funding for the NHS in England would be increased by £20.5 billion in real terms by 2024 – an average of 3.4% per year.

The cash increase to follow this up was formally announced in last November's budget, and the extra funding begins this year.

The budget allocation includes an amount to allow for inflation, and an extra £1.25bn each year for specific pensions pressures. That's why the total appears to increase by £34bn, rather than £20.5bn – from £115bn this year to £149bn in 2023-24.

This is the misleading higher figure Johnson and ministers are now trumpeting.

But the Philip Hammond's Budget statement made clear what is was worth (Table 1.7): "In June, this government committed to a new multi-year funding plan for the NHS in England, equating to £20.5 billion more a year in real terms by 2023-24".

The Health Foundation damned the increased funding with faint praise, arguing that the money would merely "help stem further decline in the health service".

The Institute for Fiscal Studies described the planned increases in health spending as "modest in the context of easily the tightest decade for the NHS since its founding."

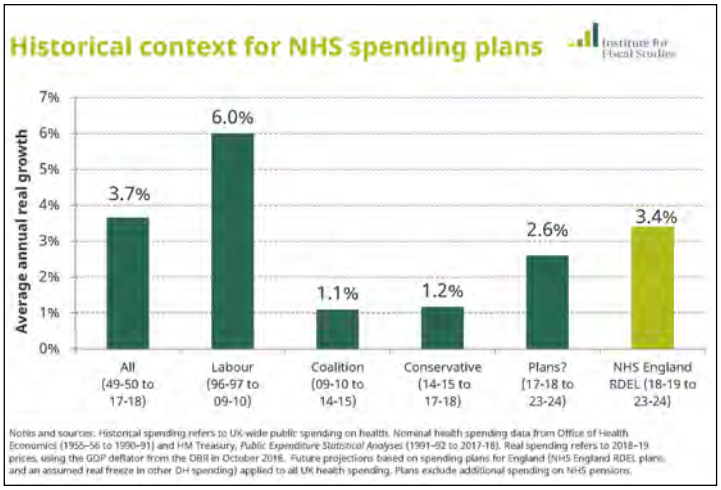
The Health Foundation and other critics have also pointed out that increases of at least 4% a year on average are needed in order to meet the NHS's needs and see any improvement in its services.

Anita Charlesworth of the Health Foundation earlier this year echoed the same view: "Healthcare funding has grown by an average of 2 per cent a year since 2010…. less than the overall rise in public spending, and below the estimated increases needed to address the lack of investment in staff and public health over recent years."

The £20.5bn increase also only applies to the part of the health budget controlled by NHS England. So other parts of the Department of Health and Social Care budget – including the education and training of doctors, nurses and health professionals and the public health grant income to councils for sexual health and children's services – get no increase, and will FALL in real terms.

In other words the accurate figure for the planned spending rise over five years is £20.5 billion – or less if inflation rises – in real terms.

By claiming it is '£33.9 billion extra' ministers are exaggerating its real value … by 65%.



Notes and sources: Historical spending refers to UK-wide public spending on health. Nominal health spending data from Office of Health Economics (1955–56 to 1990–91) and HM Treasury, *Public Expenditure Statistical Analyses* (1991–92 to 2017–18). Real spending refers to 2018–19 prices, using the GDP deflator from the OBR in October 2018. Future projections based on spending plans for England (NHS England RDEL plans and an assumed real freeze in other DH spending) applied to all UK health spending. Plans exclude additional spending on NHS pensions.

Other parts of the DHSC budget – including the education and training of health professionals – get no increase, and will FALL in real terms.

Checking up on Johnson's fake forty new hospitals

The breathless press releases and media statements at the end of September spelled out a clear message, which some Tory candidates are now reiterating in the election campaign:

"Prime Minister Boris Johnson said: 'We're providing additional funding for 40 new hospitals to be built over the next decade.'

"Health Secretary Matt Hancock said: 'I love the NHS and I'm incredibly excited to be able to launch the largest hospital building plan in a generation, with 40 new hospitals across the country.'

It's hard to understand from this over-egged hyperbole that all the Johnson government has done is provide £2.7 billion to fund just **SIX** new or refurbished hospital projects.

£100 million is also provided as "seed funding" for 21 trusts to draw up plans for another 34 hospital projects – which will potentially cost another £10 billion or more – after 2025.

This is a long way from being the biggest hospital programme in a generation: from 1997 onwards Tony Blair's government built well over 100 – albeit funded through PFI.

It's also questionable whether the 34 future projects will ever get beyond the planning stage, since they would need to be agreed and funded by a future government after at least one further election, during or after 2025.

None of the six new hospitals that have been given the "immediate" go-ahead is ready to start work for many months yet.

In **South West London** management of the **Epsom & St Helier** trust have decided the debate is about where to build a new £400 million "major acute" hospital. They will have to run a full public consultation, followed by a full business case. This story could run and run.

No quick relief for Whipps Cross

In **North East London** there will be a similarly long wrangle over the funding and size of a new hospital to replace the ageing **Whipps Cross Hospital**. The discussion has not yet even clarified where on the extensive Whipps Cross site the new building should be located.

In **Leeds,** the **Teaching Hospitals Trust** has been given the green light to build new hospitals for adults and children on the **Leeds General Infirmary** site, but the Trust board is far from ready to begin work at once: the project includes 'sympathetic redevelopment' of the Grade I listed Gilbert Scott Building.

In **Watford,** where **West Hertfordshire Hospital Trust** bosses have been "thrilled" by the funding to build a replacement, there is also an unresolved argument over the location of an acute hospital to serve the catchment area of almost 500,000 people. The Trust has promised to share their proposals "as soon as possible".

In **Harlow**, the **Princess Alexandra Hospital Trust** is free to build the long-awaited and interminably-discussed new hospital: management were "thrilled" but warned that there will be some delay before anything actually happens.

In **Leicester,** a 'pre-consultation business case', reputed to be a staggering 1800 pages long has been kept carefully under wraps. Before any new building can commence the Trust needs to brace itself for a full public consultation on reducing from three sites to two, and construct a viable Business Case.

Call for action to avert "corridor care"

John Lister

The President of the Royal College of Emergency Medicine, Dr Katherine Henderson, has urged hospital boards to take immediate action to reduce crowding in Emergency Departments this winter.

Dr Henderson said: "As the declaration of a critical incident at Nottingham University Hospitals Trust shows, winter has clearly arrived after minimal let up over the summer.

"Most departments are struggling to admit patients into hospital beds, and offload ambulances. The result is that sick and elderly and frail people are spending hours waiting on trolleys in a noisy, undignified environment.

"We are calling on hospital Boards take to take action. There must be a focus on creating capacity within the hospital to get sick patients out of the Emergency Department once they are ready to be admitted; long waits in emergency departments are associated with increased mortality."

4,000 more beds

Less than two weeks earlier the RCEM warned that the NHS needed at least 4,000 extra acute beds in England to avoid "corridor care", keep bed occupancy at a safe level, and keep emergency departments moving, between 4,000 and 6,000 staffed beds will be needed.

Dr Henderson said: "Since Quarter 1 of 2010/11 we have lost over 15,000 beds from the system.

"Performance against the four-hour standard at large A&Es was just 77% last month and declining performance is linked to declining bed numbers."

"Cuts to the bed base must be reversed otherwise we will end up seeing more patients stranded for hours on trolleys in crowded corridors.

"Bed occupancy during winter last year was an average of 93.5% - far higher than the recommended safe level of 85%. This was despite a mild winter, with the lowest number of bed closures due to norovirus in years.

"Performance against the four-hour standard at large A&Es was just 77% last month and declining performance is linked to declining bed numbers.

"This is bad for patients and demoralising for hardworking staff."

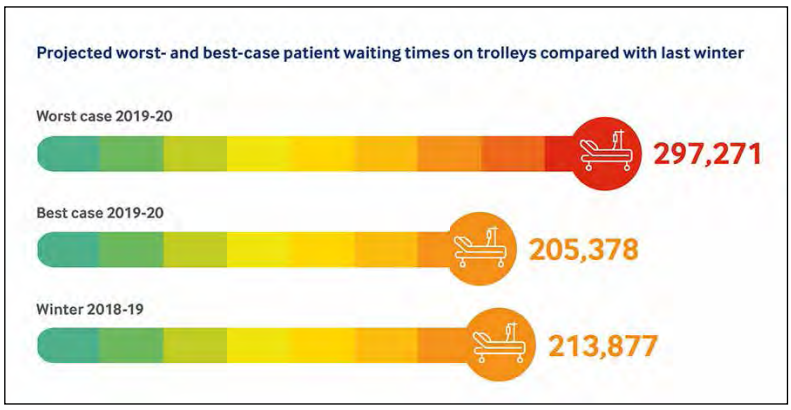
The calculation of 4,000 beds is based on the number of beds required to move to 85% bed occupancy.

However the RCEM has not calculated the numbers of consultant, junior doctor and nursing staff that would be required to allow these extra beds to be used.

With the vast majority of major NHS trusts already deep in deficit, seeking to cut spending and reliant on borrowing the funds to prop up flagging balance sheets, the cost is also a factor.

■ **The RCEM has announced that its 2019/20 Winter Flow will publish weekly aggregated performance figures from 50 trusts and boards across the UK, including the number of patients waiting 12 hours, or experiencing 'corridor care'.**

Embarrassing NHS figures postponed till after polling day



John Lister

Routine publication of the first Combined Performance and SitRep data that will show the gathering winter crisis in the NHS has been deftly postponed by NHS England to the DAY AFTER the election.

The statistics would normally be published on the second Thursday of the month – in this case polling day December 12. NHS England Statistics has now confirmed that the figures will appear on December 13.

This will be a considerable relief to the Johnson government, whose ministers would not have relished having to fend off critical questions on news media on the day voters will be making up their minds which party to support.

It's already clear that this winter is set to be yet another worst-ever for the NHS: the first hospitals have already begun declaring "black alerts" – now known as Opel 4 – in early November, and the winter's first "critical incident" was declared by Nottingham University Hospitals Trust – which has been exempt from normal reporting on its A&E performance since April because it is a pilot site trialling new targets.

All these indicators – along with the widespread record levels of bed occupancy and pressure on emergency services right through the previously relatively quiet summer months – are signs of impending crisis, and indicators that the numbers of beds and staff are insufficient.

Even before the first signs of winter the Nottingham trust's Integrated Performance report was a sea of red ink for missed targets for reducing delayed ambulance handovers, for patients marooned in beds for more than 3 weeks, for cancelled operations and for swift access to cancer treatment.

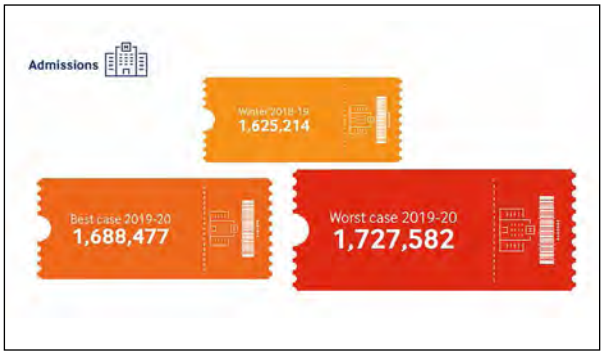
Trust finance directors are trying to wrestle down a projected deficit of £45m this year to £27m to qualify for a handout from the Financial Recovery Fund.

But the trust's finances are already propped up by £97m of borrowing, and the trust's buildings are saddled with a £130m backlog bill for maintenance.

The *Health Service Journal* notes that NUH also reported black alerts over the summer – "unusual for hospitals outside areas attracting high numbers of tourists" – and to make matters worse its urgent and emergency services were rated "requires improvement" by the Care Quality Commission in March.

Spread of 'Black alerts'

Early November has also seen black alerts at Queen Elizabeth and Lewisham Hospitals in SE London, both of which were full to capacity – but managed to avoid turning patients away, partly through the efforts of social care staff assisting to move some adult patients out of hospital more quickly.



"At the time of writing, the Government has not made any additional winter funding available to the NHS and social care to mitigate winter pressures, and with Parliament dissolved, there is now no mechanism to do so."

In Lincolnshire, where the United Lincolnshire Hospitals Trust is in its third year of special measures, the A&E is under pressure and management seeking measures including cancellation of non-urgent operations to free up beds.

Birmingham, too, is being warned to brace for a waiting times "nightmare" this winter, on the basis of analysis by the local newspaper's Reach Data Unit, which forecasts that in this one city hospitals could leave as many as 77,000 people waiting in A&E between January and March, with as few as 57.6% seen in the 4 hour target time.

Even in September only 64% of patients attending major A&Es in University Hospitals Birmingham Trust waited less than 4 hours, and the neighbouring Sandwell and West Birmingham trust was only slightly better at 67%.

BMA report

The Reach Data Unit applied the same methodology as a recent BMA report The NHS and a perfect storm of winter pressures, which warns that England's health service, trusts and GP practices are almost certain to endure "the most pressurised winter on record":

"Lack of recovery from summer, combined with other factors such as pensions taxation legislation forcing senior doctors to work fewer shifts to avoid large tax bills, and energy being spent on Brexit planning rather than winter preparedness, means the NHS is facing a 'perfect storm' this winter"

This last summer was worse than the BMA had expected, with actual performance worse than the worst case on A&E waiting times and trolley waits, with 179,000 waiting over 4 hours for a bed after a decision to admit.

The new report anticipates further increases in admissions and trolley waits, and warns "the winter could be substantially worse than our worst-case projections, especially if other factors – such as particularly cold weather and significant flu outbreaks – occur this year."

No winter funding

Perhaps most telling of all as voters are bombarded with professions of love for the NHS by government ministers is the lack of any additional funding to help services cope this winter:

"At the time of writing, the Government has not made any additional winter funding available to the NHS and social care to mitigate winter pressures, and with Parliament dissolved, there is now no mechanism to do so.

"In recent years, funding in the region of two to three hundred million pounds has been announced ahead of the winter months, but this year the NHS will receive nothing."

Beware unrealistic cancer promises as services are overrun

Paul Evans

Cancer services attract bold election promises as politicians know what the public wants to hear, but how many of these pledges can really be delivered?

The government have set a goal to save 55,000 lives a year through early detection of cancer and improved treatments, first announced by Theresa May and relaunched it in the new 10-year plan for the NHS.

In reality the NHS is so over worked that the existing government target for patients to start cancer treatment within 62 days of a GP visit has not been met for over three years.

Before the election campaign Boris Johnson's government announced a £200m investment in NHS diagnostics to upgrade and replace older mammography and diagnostic imaging equipment.

Welcome but insufficient was the conclusion of health economists, declaring that the new money is 'below what is needed to bring the UK up to an acceptable level'.

Falling behind

International comparisons show how far the NHS has fallen behind on basic capacity - in staffing and equipment.

Among EU15 and G7 countries, the UK currently has the lowest number of both CT and MRI scanners per capita, according to the Health foundation, with less than a third of that in Germany. They calculate that bringing the UK up to the average number of scanners would require around £1.5bn in extra capital spending.

Cancer UK remind us of size of the challenge – reporting that every year around 115,000 cancer patients in England are diagnosed too late to have the best chance at survival.

The weight of evidence says that identifying cancer early provides a much better chance of successful treatment, but progress with some cancers has been slower – for lung cancer almost half of people in the UK (48%) are diagnosed when their cancer is already at an advanced stage.

Cancer Research UK blame the government for not making progress in raising capacity, pointing to the critical areas like diagnosis where 1 in 10 of these NHS posts are currently unfilled.

"there's no plan to increase the number of NHS staff to cope with demand now or the growing numbers in the future" says Emma Greenwood, Cancer Research UK's director of policy."

NHS England published its interim NHS workforce plan in June, but this was not backed with any significant money to fund new education and training places.

Government pledges:

"We will save 55,000 lives through better cancer detection"

"I want to see the way we fight cancer in the NHS transformed, so we can confront this cruel disease with the best facilities to give our family, friends and colleagues the greatest chance."

Matt Hancock, health secretary

"For 41 months in a row the target for the time it takes people to start cancer treatment following an urgent referral from their GP has been breached. It has been the worst financial year on record (2018/19) for cancer waiting times with almost 34,000 people waiting too long for treatment"

Dr Moira Fraser-Pearce, Director of Policy and Campaigns at Macmillan Cancer Support

Unrealistic promises?

Last year the government pledged to catch 75% of stage 1 and 11 cancers by 2028.

It would require a big step up in activity – diagnosing an extra 100,000 patients early each year, but how realistic is this when currently cancer services are struggling to tread water?

Hospitals are continuing to miss their targets to start treatment quickly according to the latest NHS data for cancer waiting times.

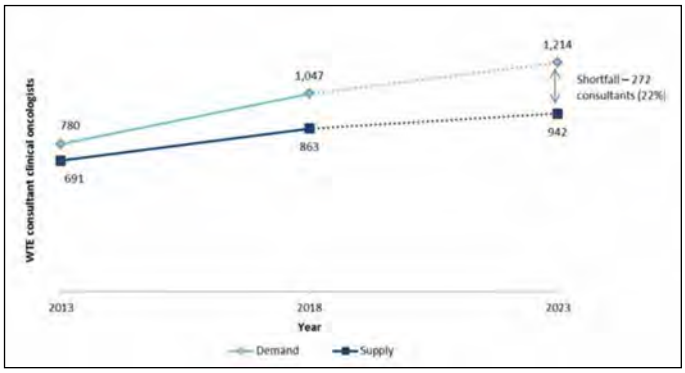
The current commitment is a maximum wait of 62 days from the time of referral by a GP: in fact nearly a quarter of patients wait longer.

Only 38% of NHS trusts meet the 62-day waiting times standard for referral to treatment for cancer patients.

A dossier of evidence collected by the Hospital Consultants and Specialists Association (HCSA) confirms the problems with understaffing.

A consultant radiologist reported that "Scan report turnaround time has gone from one week to over a month. "Unexpected and critical findings are going unreported for weeks. We are now just firefighting."

The HCSA state that delays of five to six weeks for scans are common and that patients are turning up to outpatient appointments but having to leave without their results



The growing shortfall of cancer specialists

because scans are not available.

A new study from the UK Lung Cancer Coalition (UKLCC), confirmed that there aren't enough scanners or staff to operate them, "putting the NHS far behind other European countries, including France, Germany and Spain."

In the UK, there are only seven radiologists per 100,000 people, which is "significantly below" the EU average of 12, the report said.

Understaffed

The Clinical Oncology UK Workforce Census Report 2018, warned that the workforce in clinical oncology is 18% understaffed and says that the UK needs to train double the number of oncology trainees to close the gap, but even then the gap would not be closed until 2029.

The NHS has fewer of nearly all types of staff than its counterparts overseas, relative to the number of patients.

Despite record under funding and a shortage of over 100,000 staff across the NHS is working much harder.

The number of patients referred for elective care has increased by 17% since 2013-14 and the number of patients referred for suspected cancer has almost doubled since 2010-11.

In the face of huge understaffing the NHS long-term plan, launched at the start of the year included a list of steps to improve cancer survival.

It emphasises earlier diagnosis, and sets out plans to "lower the threshold of referral".

However the NHS cannot expect to achieve the best cancer survival rates in Europe, or even to work in a safe and sustainable way until it solves its basic capacity problem – more staff and beds are needed in both hospital and community settings.

Health secretary's GP claim is misleading, but he can't hide the crisis

Paul Evans

At the end of August health secretary Matt Hancock loudly proclaimed a rise in the number of GPs, but was soon reminded this is contrary to official figures, which chart a clear decline in the number of family doctors over the last year.

"There's hundreds more GPs… we're moving in the right direction", said Hancock in a video posted on Twitter.

Statistics from NHS digital show that the number of full-time equivalent GPs has fallen by 576 over the past year, from 28,833 in June 2018 to 28,257 in June 2019.

Hancock's claim appears to be based on the total headcount of GPs which has increased by 2.7% but many of these doctors are part-time. The numbers could also have been inflated by a rise in the number of trainees.

The standard way to compare is to count the number of full-time equivalent staff and using this measure the fall in GP numbers in the last year is clear.

Overworked

The reality according to recent research is that GPs are dangerously overworked. Half of GPs are working beyond safe limits, on average completing 11-hour days and dealing with a third more patients than they should be.

The *Pulse* survey also discovered that, on average, each GP dealt with 41 patients per day. 10% say they deal with 60 or more patients a day, when evidence from European research shows that 25 consultations in a day should be considered a safe limit.

The long-term trend is no better, the number of GPs has fallen by 1300 since 2015, whilst the number of patients has risen by 1.4m, increasing the number of patients per GP by 8%.

All this explains why many of us are finding it hard to get a GP appointment. One in five patients now has to wait at least 15 days to see a GP in England, NHS figures have revealed.

'There is a point where I feel cognitively drained; after about 20 patients, there is not an iota of empathy left.'

– An overworked Hertfordshire GP

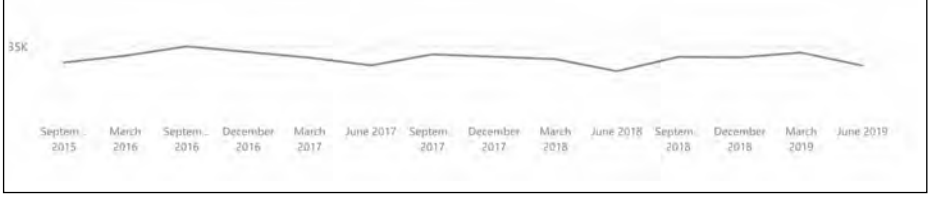
The Conservatives have ramped up expectations with an election promise to recruit 6000 new GPs, but as we report in this issue (front page), this comes after years of failed attempts to meet a target of 5000 extra.

This year new GP training places have been filled, but the tough working conditions are driving existing GPs to retire or switch to other jobs.

Research by Warwick University found that that over 40% intend to leave general practice within the next five years, an increase of nearly a third since 2014.

It takes at least 10 years to train a family doctor from entering medical school, so for the situation to improve more existing GPs must be encouraged to stay in the profession.

GP numbers 2015-19 (England – full time equivalent, NHS Digital)



American firms scooping up mental health contracts

The British market for private mental health hospitals grew by 4.1 per cent to £1.8 billion in 2018, and could grow to £2.3 billion by 2023, according to the latest report on the sector from private sector analysts LaingBuisson: – but the main customer in the market is the NHS, accounting for 90 per cent of it.

Much of this money is flowing across the Atlantic, according the Financial Times, based on new research showing the shocking extent to which American-owned health companies have taken over the provision of key mental health services in England.

US companies now run about 13 per cent of inpatient mental health beds in England, according to according to research by Candesic, a healthcare consultancy.

Half private

But in some areas, the proportion of US-owned mental healthcare facilities is much higher, such as Manchester, where half of all mental health in-patients are admitted to a privately owned hospital and a "one in four chance of the bed being provided by an American-owned company".

The imbalance is even more dramatic in child and adolescent mental health: recent reports reveal that no less than 44% of the £355m NHS spending on CAMHS care goes to private providers, and figures given in parliament last November again show how the private sector spend has grown by 27% over 5 years from £122m to £156m. .

The Candesic report estimates that in Bristol, North Somerset and Gloucestershire, 95 per cent of all mental healthcare beds are owned by private providers, two thirds of these owned by US companies.

Locked in profits

The private sector domination is most complete in the provision of "locked ward rehabilitation", in which in 2015 a massive 97% of a £304m market was held by private companies, the largest two of which are now US-owned, while 53% of all beds (locked and unlocked) for mental health rehabilitation are privately provided.

The Candesic report cited by the FT estimates that while about a quarter of NHS mental healthcare beds in England are provided by the private sector, a staggering 98% of these private facilities' earnings come from the NHS.

The big companies include the Nasdaq-listed Acadia Healthcare, which owns the Priory chain of hospitals, and Cygnet Health Care, owned by the NYSE-listed Universal Health Services, which has services worldwide including acute hospitals in Puerto Rico and the US.

Cygnet in 2017 reported operating 2,400 beds across 100 sites, with over 6,000 staff.

In the summer of 2018 it also took over the Danshell Group, operating 25 units with 288 beds for adults with learning difficulties. While Cygnet Health Care recorded a loss of £9.4m on turnover of £121m in 2017, the Group as a whole reported a very healthy profit of £40m on turnover of £334m.

The Care Quality Commission has just rated the Priory's Ellingham Hospital, in Attleborough, Norfolk, "inadequate" after it found that conditions, which included wards for children and adolescents, were "unacceptable".

KATE MISHKIN | Gazette-Mail

May 2019: in Charleston U.S. Attorney Mike Stuart announces a $17 million settlement with Acadia Healthcare over Medicaid fraud

Inadequate

Another two of the 53 facilities owned by the Priory in England are rated inadequate and a further six require improvement, according to the CQC, though the Priory said it frequently "takes on the most difficult cases which other hospitals aren't able or willing to treat".

Cygnet, runs 140 services across the UK: it closed a psychiatric unit in Durham earlier this year, after the BBC's Panorama filmed staff abusing patients.

It has since closed another hospital while a further five require improvement and three are rated inadequate by the CQC.

One mental health manager at the South London and Maudsley Foundation Trust told the FT the trust tries to avoid using private sector suppliers because they "inevitably keep the patients for too long as they have no incentive to encourage them to return to the community".

In Bristol, North Somerset and Gloucester-shire, 95 per cent of all mental healthcare beds are owned by private providers, two thirds of them owned by US companies.

Broken promises

In July 2017 Theresa May's new government promised 21,000 new posts for the mental health workforce to treat an extra million patients a year. Jeremy Hunt promised an additional 4,600 specially trained nurses working in crisis centres.

But the latest figures supplied by NHS Digital to NHS Support Federation confirm that there are 6,400 fewer mental health nurses and health visitors now than there were in 2010.

While there has been an increase of 2,108 community mental health nurses, the category of "other" mental health nursing – mainly hospital staff – has been cut by 26% – and fallen continuously since David Cameron first took office.

The number of nurses per patient has also dropped. In 2013 there was 1 mental health nurse for every 29 patients accessing services, by 2018 that had fallen to 1 for every 39 patients. 10% of specialist mental health posts are unfilled.

Just 4 in 10 people who need it receive mental health support.

But there's no relief in sight: the NHS Long Term Plan aims to be reaching just 35% of young people who need care … in ten years time.

Royal College maps a way towards less overcrowded wards

Despite warm words about 'parity of esteem' for mental and physical health since 2011, mental health services are the poor relation of the NHS, comprising 23% of NHS activity, but receiving just 11% of its budget.

A new report commissioned by the Royal College of Psychiatrists, Exploring Mental Health Inpatient Capacity, attempts to work forward from the current serious shortages of beds and unacceptable numbers of patients dispatched often long distances for "out of area treatment" (OATs).

The starting point for this study is the disparity in resources and treatment for mental health patients, for whom inpatient beds for those who need them have been cut by 73% since 1987 (from around 67,100 to 18,400) while numbers of "general and acute" beds have fallen by 44%.

While average length of stay in acute hospitals has fallen rapidly, the average length of stay for mental health remains largely unchanged over 30 years, at 7 weeks.

Raised threshhold, reduced admissions

The reduction in number of beds available in mental health services has been managed "largely through a reduction in the number of people admitted to hospital, and in some regions by the use of out of area placements.

"The thresholds for admission to a mental health bed have increased; the level of mental ill health of people admitted to hospital in 2018 was higher on average than individuals admitted in 2013.

"Furthermore, patients discharged in 2018, although deemed clinically fit for discharge, were on average less well than patients leaving hospital in 2013."

The RCP explains their approach:

"We commissioned this analysis to support our ambition that a psychiatric bed is readily and locally available for anyone who is acutely ill and in need of inpatient care.

"It is unacceptable for anyone under these circumstances to experience a lengthy stay in the emergency department, to be sent away from their local area to receive the care they need, or to be admitted to a general and acute bed where there is a relative lack of dedicated mental health nursing and psychiatric expertise.

"It is also a matter of equality. It would never be deemed acceptable for someone requiring acute coronary care to be admitted to a psychiatric ward."

Extra 1,060 beds

The report calls overall for an increase of 1,060 acute mental health beds, but notes that the problems of capacity are not evenly distributed and there are more severe problems in a few areas with the highest level of inappropriate out of area placement over the past two years:

● **Bristol, North Somerset and South Gloucestershire;** ● **Devon;** ● **Hampshire and the Isle of Wight;** ● **Lancashire and South Cumbria;** ● **Lincolnshire;** ● **Norfolk and Waveney and** ● **Nottinghamshire.**

However the College also argued that those areas with persistent 95 per cent plus bed occupancy should also consider investing in additional local psychiatric beds, notably: ● **Birmingham and Solihull;** ●**Cornwall;** ● **Mid and South Essex;** ● **North Central London;** ● **South East London and** ● **Sussex and East Surrey.**

Review

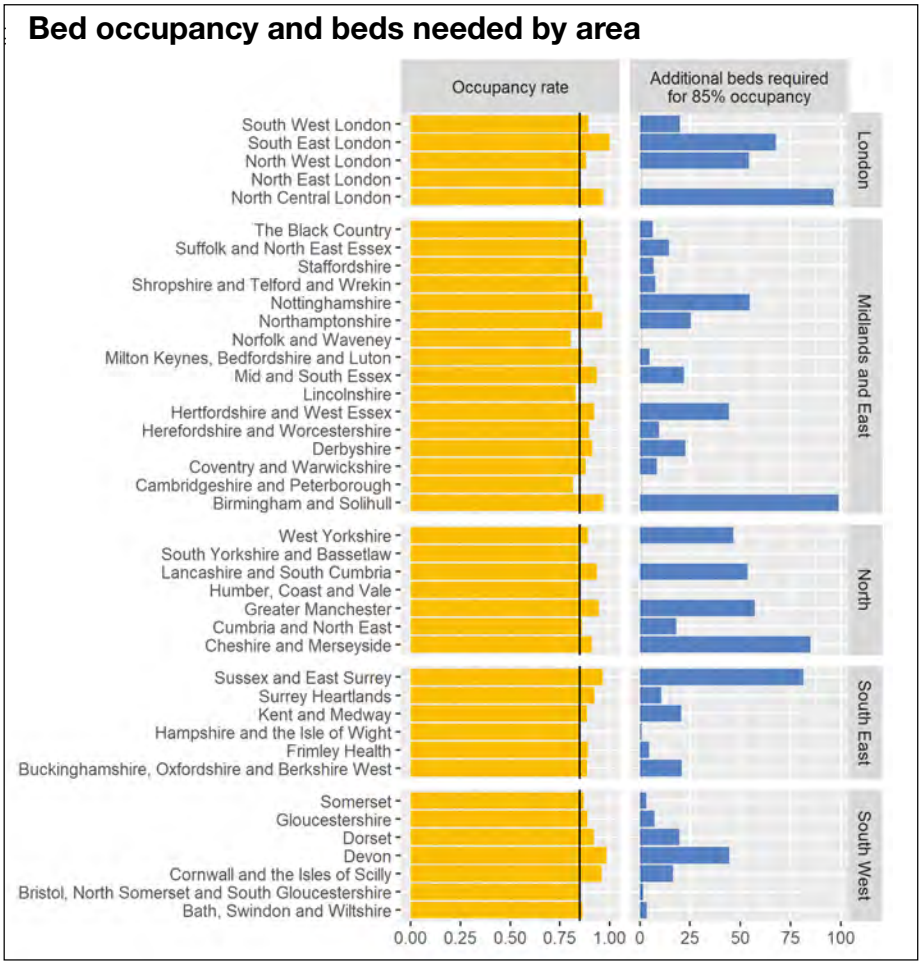
In addition the College is pressing for a wide-ranging review of the mix of services provided and their effectiveness, to "maximise the therapeutic value of inpatient stays and undertake a local service capacity assessment", and urging commissioners to invest in high quality community mental health services.

But the bold call to reverse the continuing decline in bed numbers, with colourful graphics to highlight the numbers of additional beds requires to bring occupancy down to 85% and eliminate OATs will grab most attention.

While recent government announcements have reinforced feelings that mental health is treated as a poor relation of acute hospital care, this argues a strong case for more funding – explaining just where it needs to be spent.

"It would never be deemed acceptable for someone requiring acute coronary care to be admitted to a psychiatric ward"

Bed occupancy and beds needed by area



Charges and the 'Hostile Environment' in the NHS

Over the last two years, the once secret scandal of NHS charges for anyone unable to prove their entitlement to free care has provoked a storm of opposition from health workers unwilling to police the 'hostile environment'.

Keep Our NHS Public groups are working alongside campaigners from "Docs Not Cops", "Patients Not Passports", Medact, and Maternity Action.

The charges, broadly aimed at migrants but also affecting the Windrush generation, damage individual and public health. As the thin end of the wedge, they threaten wider charges for NHS treatment. They undermine the principle of universal health care, and contradict the NHS Constitution, medical and nursing ethics, and the responsibilities of all NHS staff to protect confidential information.

Instructing clinical and admin staff to act as border guards, places them in impossible contradictions and makes healthworkers unintentionally complicit with a policy that many feel is racist, and which may widen with Brexit.

GREG DROPKIN gives an extended overview of the problem and the campaigning around the issue.

Save Lewisham Hospital campaigners questioned Lewisham and Greenwich Trust over a *Guardian* report on the use of bailiffs to chase NHS patient debt. The Director of Midwifery and a consultant midwife expressed support, and were already auditing maternity outcomes.

The Deputy Finance Director mentioned MESH, the Message Exchange for Social Care and Health.

Campaigners were shocked to learn that the details of suspected "overseas visitors" are passed to the Home Office through MESH, even in batches of 5000 booked for outpatient clinics. The Home Office also contacts the Trust, telling them to charge people they suspect may have had care there.

The Trust claimed to avoid racial profiling via "objective" methods

Maternity

Last year, Maternity Action published "What Price Safe Motherhood?" based on anonymous interviews by Rayah Feldman with undocumented migrant women, about their experiences with maternity care. Many were victims of abusive relationships with men, compounded by the hostile environment.

"Natasha" overstayed her student visa and was deserted by her partner when she became pregnant. After her miscarriage, Natasha received an invoice for £4,900, a letter requesting payment within 7 days, and a letter from a Debt Collection Agency.

As a result, she was afraid to go back for a check-up or to find out what had caused this miscarriage or a previous one.

"My baby was buried and I couldn't even go. I was just so scared they were going to come and detain me. I went to see my GP, I was still bleeding then. They had to take me to the theatre to do a D&C. I haven't had any examination to see if it is all OK.

"At times my period is so painful, I feel cramps when I sit down, when I get up I can hardly walk sometimes. A lot of clots... I am scared to go to the hospital because I don't know how I will be able to pay. Even just to hear what caused the death of my baby. I am just thinking 'was I stressed?', 'was I not eating well?', 'was it a time I slipped on the stairs?' Or was it a medical problem? I don't know."

Vigil outside Lewisham Hospital

Duty of care

A new Maternity Action report "Duty of Care" highlights the contradictions facing staff.

The Nursing & Midwifery Council Code requires all nurses and midwives to "respect and uphold people's human rights" and "act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care."

One specialist midwife told of a refused asylum seeker with HIV who declined to continue antenatal care after receiving a large bill. She was considering delivering the baby at home without professional help.

Although HIV treatment is exempt from charging, maternity care is not. But without proper treatment, a woman may risk transmitting HIV to her baby during labour or afterwards. Further, HIV-positive women will be charged a higher price for their maternity care by virtue of their HIV diagnosis.

Her specialist midwife said "It's horrific, she doesn't trust anyone any more. She's very negative regarding her pregnancy.

She felt that the midwife in the booking was quite judgemental. Unfortunately it's left a feeling that people along the way are quite judgemental in considering why she's not married."

The midwife managed to access additional funding to continue the woman's antenatal care at home.

developed by personal credit checking company Experian, who share data with Trusts who then focus on those without credit history.

As the Health Service Journal reported, NHS Improvement, which oversees all NHS Trusts, began a pilot to extend the scheme without checking its legality, let alone morality.

NHSI emailed 51 Trusts explaining the aim to "refine a system that can conduct bulk residency checks on all admissions and referrals in secondary care", and to establish whether "this is an economically viable solution for use in all Trusts".

NHSI did not assess the impact on data protection:

"NHS Improvement has not reviewed Experian's processes and data sharing agreements for compliance either with GDPR or Caldicott principles." It advised Trusts to take their own legal advice.

Experian developed this system in partnership with Lewisham by 2015. The Trust now plans an independent inquiry. The campaign may propose Terms of Reference.

Many Trusts use the NHS England Pre-Attendance Form template. Patients sign their agreement to a Declaration which begins:

"This hospital may need to ask the Home Office to confirm your immigration status to help us decide if you are eligible for free NHS hospital treatment. In this case, your personal, non-clinical information will be sent to the Home Office.

"The information provided may be used and retained by the Home Office for its functions, which include enforcing immigration controls overseas, at the ports of entry and within the UK.

"The Home Office may also share this information with other law enforcement and authorised debt recovery agencies for purposes including national security, investigation and prosecution of crime, and collection of fines and civil penalties.

"If you are chargeable but fail to pay for NHS treatment for which you have been billed, it may result in a future immigration application to enter or remain in the UK being denied. Necessary (non-clinical) personal information may be passed via the Department of Health to the Home Office for this purpose."

NHS Improvement, which oversees all NHS Trusts, began a pilot to extend the scheme without checking its legality, let alone morality.

In law, NHS Trusts must determine if a patient is chargeable, but need not pursue national security, crime, fines or civil penalties.

The Pre-Attendance Form is a generalized fishing expedition which directly contradicts Caldicott Principles of information governance which apply to all NHS staff. For example:

"Principle 2 - Don't use personal confidential data unless it is absolutely necessary

"Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s)."

In March 2017, Public Health England wrote to the Health Select Committee (see pp 18-26) with evidence that sharing data externally acts as a deterrent to patients seeking healthcare:

Charging regime

Patients are checked for their entitlement to free NHS care, and this can be investigated by "Overseas Visitor Managers" in NHS hospitals. A&E and primary care are not currently charged.

There are exemptions for treating certain conditions (e.g. HIV, TB, trauma caused by torture) and for certain persons (e.g. refugees, asylum seekers).

People do not pay if they are "ordinarily resident" in the UK, but this term is undefined and is based on case law. A person's immigration status is fluid and NHS charges may apply during a possibly lengthy appeal process.

People from outside the European Economic Area / Switzerland are only deemed "ordinarily resident" if they have "indefinite leave to remain" in the UK.

Visitors with a visa over 6 months can pay the Immigration Health Surcharge, currently £400 / year per person to gain access to free NHS care. Care which is "immediately necessary" or "urgent" cannot be delayed and may still be charged, but otherwise the patient must pay upfront before treatment begins.

Charges are set at 150% of the normal tariff for people from outside the EEA / Switzerland. The Home Office can be told of unpaid debt, which may jeopardise immigration status.

For a full explanation and history, see Patients Not Passports

"Effective communicable disease control requires easy and early access to clinical investigations, screening, diagnostic testing, treatment and preventative measures.

"Patients provide information to healthcare providers with explicit assurances about confidentiality and this is the basis for unfettered sharing of demographic and personal health data by patients with health systems.

"If patients have concerns that their personal information, even simple identifiers, could be shared with law enforcement or immigration enforcement agencies for the purposes of pursuing them for actual or alleged breaches of law or immigration rules, then this risks creating a real barrier to their engagement..."

Reporting Debt in a City of Sanctuary

In July, the *Yorkshire Evening Post* published a letter from KONP Co-chair and retired Consultant Dr John Puntis, noting the ironic contrast of "Leeds as a city of sanctuary and its great tradition of welcoming immigrants" with

"the 'hostile environment' which now requires Leeds Teaching Hospitals NHS Trust (LTHT) to charge vulnerable and impoverished migrants for healthcare".

Dr Puntis also asked the Trust "Why does LTHT report patients with debts over £500 to the Home Office when such reporting is not mandatory?"

The Trust replied: "Although not a mandatory requirement, compliance is expected by NHS Improvement. The Trust has an obligation to take all steps available to recover the cost of providing care to those not eligible for NHS treatment and prevent the loss of public funds."

The issues are being raised within Unite, whose branch chair also chairs the Trust staff-side committee.

Royal Liverpool Hospital

In November 2018 KONP Merseyside and the Save Liverpool Women's Hospital campaign organised a Patients Not Passports conference, supported by Unite North West, Liverpool TUC, Unite branches and Garston & Halewood CLP. Speakers included Maternity Action, Docs Not Cops, Medact, South Yorkshire Migration and Asylum Action Group, Greater Manchester Law Centre, and These Walls Must Fall, with support from Refugee Women Connect and Asylum Link Merseyside.

Consultant Microbiologist Dr Jonathan Folb from the Royal Liverpool hospital attended and began raising the issue with Junior Doctors and other Consultants.

In January, 60 medics and public health academics met at the Medical School, with input from Docs Not Cops and KONP. Medics expressed outrage at the charges and their implementation in the hospital. KONP later learned that the charges to "overseas visitors" in 2018-19 amounted to 0.12% of total patient care income, and only 0.04% was actually paid, negating any economic argument for the regime.

In a survey of Junior Doctors and Consultants, over 100 of each group responded, and over 90% of each stated opposition to the charges. The Joint staff-side, with unions representing all other NHS staff in the hospital, is also supportive.

A campaign statement inviting signatures was placed on the Medact website.

The local GP surgery dealing with asylum seekers and refugees wrote to the campaign, ccing the Trust Interim CEO and Chair, "[To] restrict access to necessary healthcare is, in the opinion of the Board of PC24, neither in the spirit of the NHS nor the ethos of Liverpool as an asylum city. As an organisation, Primary Care 24 fully supports your campaign and will help in any way we can to bring this practice to an end."

In July, medics convened a Grand Round (to discuss issues and individual cases), with participation from the GP surgery and migrant support group "Refugee Women Connect".

The Acting Medical Director invited Consultants to redraft the Trust policy. It turned out there is currently no agreed policy, only a draft, but the charging regime is operating.

This offer posed a difficult question. Medics had to decide whether accepting it would make them complicit in a regime they completely oppose.

On the other hand, patients are being charged, posters are up and women wearing a headscarf have been asked for their passport at A&E.

The Overseas Visitor Team become involved before clinical teams have had time to properly assess urgency or clinical exemptions. The OVT read and append the clinical notes, and interview relatives while patients are undergoing treatment, pulling in staff to interpret.

Over the summer, medics decided to redraft the policy. On 23 Oct, the second anniversary of the introduction of upfront charges, a campaign meeting attended by Consultants, senior staff, Junior Doctors from the Royal, Aintree and Warrington hospitals, the Walton Centre, medical students and a former interpreter endorsed this approach and agreed to submit an updated version for negotiation with Liverpool University Hospitals NHS Foundation Trust (merger of Royal and Aintree).

The draft policy is introduced as an interim measure to mitigate harm as far as possible while remaining within the 2015 and 2017 Regulations.

The draft opens by referring to "First Do No Harm", the GMC Duties of a Doctor, the Duty of Care covering all staff and the Trust itself, and the Caldicott Principles.

It acknowledges the concerns expressed by staff and endorses calls from the British Medical Association, Academy of Medical Royal Colleges, and the Royal College of Midwives, for the regulations to be repealed or suspended pending a full and independent review into the impact of charging on individual and public health.

The draft policy is introduced as an interim measure to mitigate harm as far as possible while remaining within the 2015 and 2017 Regulations. It sets out procedures to identify exemptions, with charges as the last resort and without a target in the Business Plan.

No charges, publicity or inquiries will occur in the Emergency Department or Sexual Health (GUM). Only clinicians will access clinical data. Limited non-clinical data will only be shared with the Home Office on an individual basis with patient consent, in line

with Caldicott, after other attempts to find exemptions have failed.

Patients will have access to advocates and interpreters on request, and appeal rights. The Trust will not use external debt recovery agencies and will not report debt to the Home Office. The draft sets out roles and responsibilities for each staff group including the Overseas Visitor Team. It requires the Trust Board to monitor the policy's full impact on Patient Safety, Equality and Diversity and on the health of patients who present, or could otherwise be expected to present, to the Trust.

Major problems will remain until the law is repealed. But campaigners and hospital staff hope that Liverpool University Hospitals will choose to stand alongside the BMA and others in calling for a change in the law, while protecting patients and staff in the interim.

The BMA Mersey Junior Doctors Committee wrote to the campaign in July, expressing support in line with BMA policy (below), and concluding:

We also as a local committee support your call to Royal Liverpool University Hospital to make a public statement acknowledging the concerns of its staff, and encourage them to support the calls from BMA and other key stakeholders to abandon charging, and to take immediate interim measures to reduce harm to vulnerable individuals, ensuring the NHS is free for all at the point of delivery.

BMA and Royal Colleges

The **BMA Annual Representative Meeting (ARM)** in June overwhelmingly adopted Motion 42 from Tower Hamlets Division:

That this meeting notes that in a pilot to check eligibility for free NHS Care only 1/180 people were deemed ineligible and:-

i) this meeting believes that it 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) that 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.

The **Academy of Medical Royal Colleges** called for "the suspension of the NHS charging regulations pending a full and independent review of the impact on both individual and public health" and "a clear separation of roles between immigration enforcement activities and the provision of healthcare".

Campaigners and hospital staff hope that Liverpool University Hospitals will choose to stand alongside the BMA and others in calling for a change in the law, while protecting patients and staff in the interim.

The **Royal College of Midwives** Chief Executive Gill Walton, introducing the Maternity Action "Duty of Care" report, stated:

"We believe that maternity care should be exempt from NHS charging altogether to protect and promote maternal and newborn health. The current charging regime needs to be suspended until the government can prove this policy is not doing any harm and jeopardising our shared ambition to make England the safest place in the world to have a baby."

Labour

Labour Party Conference agreed NHS Composite 2 which includes:

"Conference supports health workers' duty of care to migrants and opposes migrant charges. Labour will repeal Sections 38 and 39 of the Immigration Act 2014 and subsequent regulations which implement migrant charges."

A motion from **Labour Women's Conference** was adopted overwhelmingly.

"Annual Women's Conference deplores the 2017 introduction of NHS charging regulations requiring undocumented and destitute migrant and refugee women to pay 'up front' charges for ante-natal and maternity care.

…

"We resolve to:

"call on the Secretary of State for Health and Social Care and the Government to rescind the Regulations – and meanwhile suspend them pending research on their impact

"call on the Shadow Secretary of State for Health and Social Care to express Labour's opposition to charging and agree to rescind the policy under a Labour government".

FURTHER INFORMATION:

ARTICLES AND BRIEFINGS

- Another key Johnson claim on the NHS demolished
- Healthcare workers blockade NHS England and hold vigils at six Hospitals to protest charging for migrants in the NHS
- British politicians' NHS hypocrisy laid bare today on the global stage
- How NHS staff are fighting back against the 'hostile environment'
- Patients Not Passports Briefing:
- Patients Not Passports toolkit:
- Patients Not Passports Letter to Health Secretary:
- KONP leaflet:
- KONP:
- Speech by Cathy Augustine:
- Speech by Sonia Adesara: (section begins 8:05)
- Maternity Action legal challenge:
- Speech by Sarah Davies:

Contacts

If you are a member of a trade union which organises within the NHS, please seek their support in defending universal healthcare. Active campaigns include East London (Newham, Waltham Forest, Hackney, Tower Hamlets, Barts Hospital), Lewisham, Southwark, Brighton, Bristol, Oxford, Cambridge, Nottingham, Leeds, Manchester, Liverpool, and many other individuals.

Medact: Docs Not Cops: Patients Not Passports: Doctors of the World: Maternity Action: Keep Our NHS Public:

THE lowdown

Health news, analysis and campaigns.
NUMBER 14, November 25 2019

Informing, alerting and empowering NHS staff and campaigners

More fake promises in Tory manifesto

John Lister

Prime Minister Boris Johnson is at least consistent in one respect: his major statements begin to be discredited within minutes – as soon as anyone can check the details. Just recently we have had false and discredited claims on:

£1.8 billion of "new money" for capital investment, most of which was not new

Claims to be building 40 new hospitals – when the real figure is six, some of which are rebuilds, with decisions on the others not due until at least 2025.

Claims to be spending "record amounts" and £33.9 billion extra by 2024, when the real terms increase is just £20.5 billion, a 3.1% annual increase, much less than the pre 2010 average annual increases, and less than the 4.1% called for by the BMA and leading think tanks.

The launch of the threadbare 59-page Conservative Manifesto was another classic example. Headlines were first grabbed by a promise of 50,000 "more nurses," although committing to no timescale and not defining whether this is full time equivalent or a headcount.

Debunked

This was swiftly debunked, by the *Guardian* and *Independent,* by *Nursing Notes* and by Full Fact. *The Independent* pointed out that at most 31,500 would be "extra" nurses:

"The 50,000 figure includes an estimated 18,500 existing nurses who will be encouraged to remain within the NHS or attracted back after leaving …. The recruitment plan also includes 14,000 new nursing training places … as well as 5,000 more nursing apprentices and 12,500 recruits from abroad …."

The viability of recruiting so many overseas nurses given the brutal immigration policies unveiled by the Johnson government has also been questioned by *Nursing Notes* and the Royal College of Nursing.

Full Fact has also raised doubts over the minimal £879 million allocated to funding the extra nursing staff and reinstating the bursary for student nurses that was axed by the Tories — with a minimum of £5,000 per year.

They argue that the full cost of employing 50,000 Band 5 nurses could be as high as £2.6 billion per year. And with the latest figures showing 39,500 nursing posts vacant, an extra 50,000 would increase numbers by just 10,000.

The promise of 6,000 extra GPs also grabbed attention, with the related promise of 50 million more appointments each year. The promise had already been made by Matt Hancock – and exposed by *Pulse* magazine as another misleading claim, including 3,000 trainees along with 3,000 qualified GPs in the total.

Launching the manifesto in Telford, Johnson even managed to mislead on the planned downgrade of the local A&E unit, falsely claiming it had been saved – until a later statement confirmed the downgrade.

The BMA response to the Manifesto pledge pointed to the abysmal failure of governments since 2015 to deliver on Jeremy Hunt's infamous promise of an extra 5,000 GPs by 2020: in fact numbers have fallen by 1,000 in the past five years.

So what of the Manifesto promise to scrap fees for parking at English NHS hospitals, billed by the *Sunday Telegraph* as axing charges for "millions"?

The *Mirror* was the first to look closer and show that the promise is very cagey, making parking free only for those "in greatest need". So unless you are disabled, a "frequent" outpatient attender, a parent of a sick child staying overnight or a night shift NHS worker you will still have to fork out: the majority of staff, outpatients and almost all hospital visitors will still have to pay.

And so it goes on: other pledges are equally slippery and misleading. Social care is fobbed off with an extra £1 billion a year, and the problem kicked back into the long grass. Mental health gets another gush of warm words, but no new resources.

Voters who want a decisive break from the current crisis and decline of the NHS will need to look to parties other than the Tories.

The Lowdown will soon publish an overview of the manifestos of all the main parties.

IN THIS SECOND PRE-ELECTION ISSUE

Desperate shortage of mental health care for young people

The chronic lack of provision of child and adolescent mental health services has been repeatedly highlighted by reports from the charity YoungMinds.

The failure of government and NHS England to invest in supportive services ignores statistical evidence showing the scale of the problem, with 1 in 8 children having a diagnosable mental health disorder, and 1 in 6 young adults (aged 16-24) showing symptoms of a common mental disorder such as depression or an anxiety disorder.

The death toll is rising, with suicide the most common cause of death for both boys (16.2% of all deaths) and girls (13.3%) aged between 5 and 19 in 2017.

And where mental health problems continue, they are life limiting: people with severe mental health illnesses tend to die 15-20 years earlier than those without.

Target of 35%

In 2016 NHS England's document Implementing the Five Year Forward View set an uninspiring target of reaching 35% of children and young people with mental health needs by 2020

In January NHS England's Long Term Plan claimed that "access is rising in line with our plans and, in 2017/18, around 30.5% of children and young people then estimated to have a mental health condition were able to benefit from treatment and support, up from an estimated 25% two years earlier."

But the gaps are still enormous.

YoungMinds asked more than 2,700 young people about their experiences of looking for support for their mental health: fewer than one in ten (9%) said that they found it easy to get support, and only 6% of young people who had looked for support agreed that there is enough support – 81% disagreed.

Of those who had received support from Child and Adolescent Mental Health Services (CAMHS), many had experienced delays at every stage: 44% said that they found it hard to get a referral, 61% said that there was a long wait between referral and assessment, and almost a third (32%) said there was a long wait between assessment and treatment

Only 11% said that they had received support from CAMHS and didn't face any barriers.

GPs can't cope

A YoungMinds survey of 1,008 GPs published in early November found that 90% of GPs had seen a rise in the last three years of young people seeking mental health help, but over three-quarters of them (77%) felt community support for child mental health problems was not good enough, and almost the same number did not feel confident that their referrals to CAMHS would result in treatment.

Mental health charity Mind revealed the latest figures from NHS Digital show a big increase in the number of cancelled appointments by CAMHS has increased since 2017-18.

175,094 appointments in CAMHS were cancelled between August 2018 and July 2019 – an increase of 34,767 (20%) from the previous year.

One in five

Only in five of the GPs surveyed by YoungMinds said they had received enough training to handle mental health issues in young people: 59% disagreed.

Almost half of the GPs said they often acted beyond their competency by supporting young people with mental health problems.

The Guardian has highlighted NHS figures that show average waiting times to access CAMHS in England have fallen slightly, from 57 days in 2017-18 to 53 days last year. However, that does not include under-18s who were referred but still waiting at the end of the year to hear from the NHS as to when they would be seen.

The number of young people referred to CAMHS rose by 18% from 343,386 in 2017-18 to 405,479 in 2018-19.

Latest figures confirm downward trend in NHS performance

In October only two out of 119 hospitals with a major A&E department met the target of ensuring patients wait no more than four hours from the decision to admit until admission: more than 80,000 patients waited more than four hours, 63% higher than a year ago.

Of these, 726 patients waited more than 12 hours (240% higher than in October 2018).

Around one in six of those attending an A&E were not seen, treated and admitted or discharged within 4 hours, described by King's Fund chief executive Richard Murray as the worst performance since records began, "and this before winter has even started".

The target to admit, discharge or transfer at least 95% of people within 4 hours of arriving in A&E has not been met since the second quarter of 2014/15. However most of the delays are in the treatment of the more serious "Type 1" A&E attenders: Over 99% of minor (type 3) patients were seen within the 4-hour target time in A&E departments in 2018/19, in comparison to just 81.4% in major (type 1) A&E departments.

Just 77% of patients had their first definitive treatment for cancer within 62 days of an urgent GP referral in September 2019, down from 78% at the end of September 2018, and well short of the operational standard that specifies that 85% of patients should be treated within this time.

Delays in discharging patients after their treatment amounted to 149,384 days in September 2019, an increase of 3% from September last year. These days equate to a daily average of 4,979 beds (equivalent of ten general hospitals) occupied by delayed patients in September 2019 compared with 4,820 last year.

The main reason for delays in September 2019 was "Patients Awaiting Care Package in Own Home", which accounted for 21% of all delays. Half of the delays for this reason are attributable to Social Care, 30% to NHS and 20% to both.

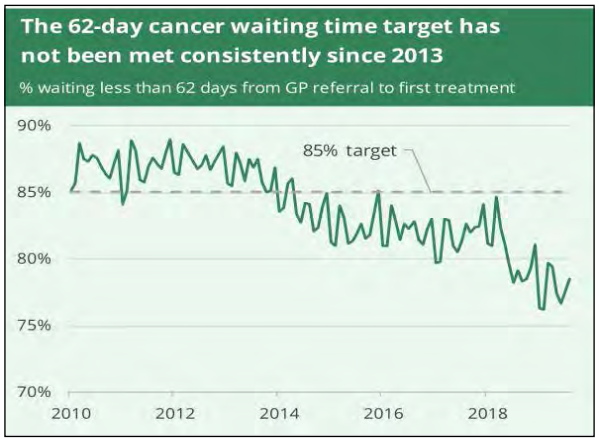
Social care has suffered real-terms cuts, with

Death toll from social care

The actual austerity-driven cutbacks in social care spending that have continued since the 2017 general election have taken a heavy death toll according to research by Age UK. They calculate that 74,000 or more older people have died waiting for social care, equivalent to 81 per day – more than three per hour.

1.7 million calls for help and support went unanswered, many of them because people were deemed not sufficiently serious to meet tough eligibility criteria for social care.

Age UK's manifesto for the 2019 election estimates that 4.1 million of England's 10 million people over 65 are in poor health, living with one or more serious long term health condition: more than a third of these (1.5m) have an unmet need for care – ranging from help with washing, dressing

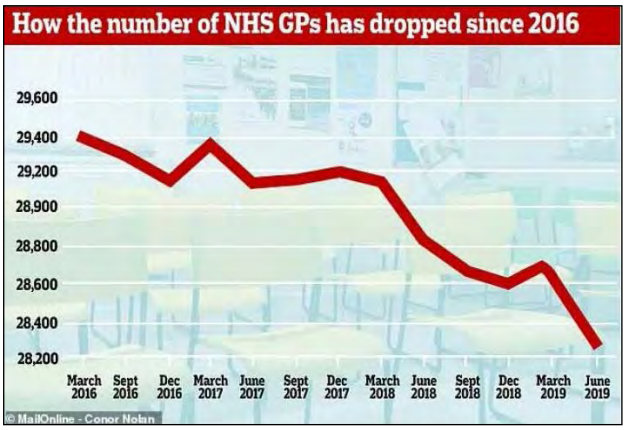


government spending on adult social care in England cut from an average of £346 per person in 2010/11 to £324 in 2017/18.

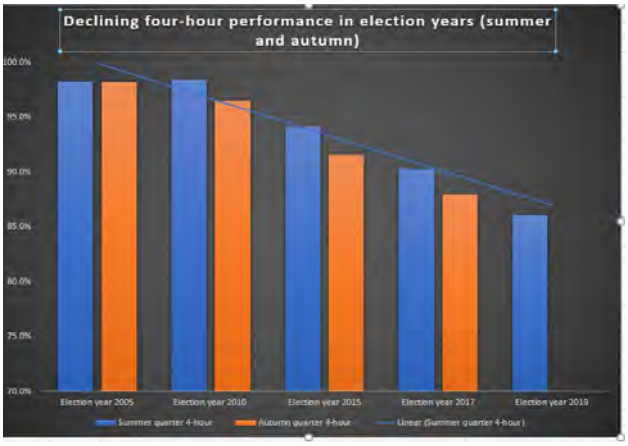
85% of patients on the waiting list for elective treatment at the end of September 2019 had been waiting less than 18 weeks, well short of the 92% standard, and down from the 86.7% in September 2018: the number of patients waiting over 18 weeks rose 22% from 550,000 to 672,000.

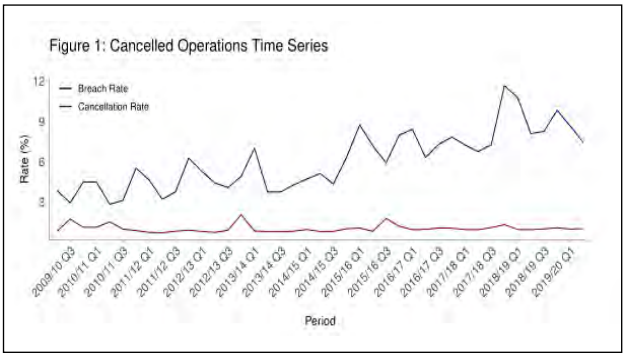
The Health Foundation points out that people are being added to the elective waiting list faster than the NHS can treat them. "The total number of people on the waiting list is now over 4.5 million, having grown steadily from 2.5 million in April 2010."

While numbers of diagnostic tests have increased over the past year, 3.8% of the patients waiting for one of the 15 key diagnostic tests at the end of September 2019 had been waiting six weeks or longer from referral, compared with the operational standard of less than 1%.



Delays in discharging patients after their treatment days equate to a daily average of 4,979 beds (equivalent of ten hospitals)





cuts: over 3 people per hour

and using the toilet to more intensive support in a care home.

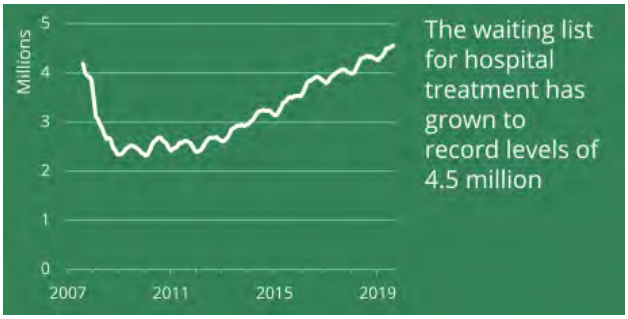
Age UK says it estimates the number will rise to 2.1 million by 2030 if governments fail to act. It is calling on the next Government to secure the immediate future of care through investing at least £8 billion over the next two years.

1.6m older people are living in poverty. Around one in ten older people live with frailty.

Improvements in healthy life expectancy have peaked in recent years, especially in deprived areas, where at age 65 people can expect 7 fewer years in good health than those in the wealthiest areas.

Social care spending on over 65s was cut by 25% between 2010 and 2018.

■ While Health Secretary Matt Hancock and NHS England are obsessed by digital solutions and apps, 3.4 million over 65s have never used the internet, and another 500,000 have done in the past but no longer do so. Most over 75s are not online.



Public health cuts expose hollow claims of "one nation" approach

Public health cuts have been biggest in poorest areas

Boris Johnson opened his election campaign with a fresh claim to be a "one nation" Conservative – after expelling two dozen actual one nation Tories who refused to vote for his 'deal'.

The term "one nation" was originally coined by Tory Benjamin Disraeli back in the 1830s in reference to the need to reach out for support to the working classes: since the 1940s it has generally meant a paternalistic view of the welfare state.

But of course the welfare state has since been savaged by the Thatcher government in the 1980s and the Tory-led governments since 2010, with austerity-driven cuts that have widened inequalities between different areas and between rich and poor.

Now as he bids for the votes of pro-Brexit workers, Johnson appears to be donning the "one nation" mantle.

The Independent reported: "In an attempt to drag his campaign back on track, Mr Johnson vowed to usher in a "One Nation Conservative" government that would focus on making the UK the "greatest place to live, to raise a family, to start a business, to send your kids to school"."

But evidence of his party's commitment to the opposite approach can be found in the hefty cuts in public health spending that have been imposed in the past 5 years, which land most heavily on the poor, and help to further widen the inequalities in healthy life expectancy between the richest and the most deprived areas.

Local government spending

A recent report from the IPPR has brought together the evidence and calculated the scale of the cutbacks in public health services, which have been driven on by a truly massive 60% cut in local government budgets between 2010 and 2020.

The decline in public health spending adds up to £850m since 2014, with the main cuts imposed on drug and alcohol services (£261m), and sexual health services (£196m): there have also been cuts in smoking cessation initiatives (£85m), health checks protection and advice (£72m) obesity services (£26m) and "miscellaneous" public health services (another £220m).

Public health spending has been reduced from a peak of £2.9 billion to £2.3bn across the whole of England, less than 2% of the NHS budget.

Annual spending has been reduced from a peak of £2.9 billion to £2.3bn across the whole of England, less than 2% of the NHS budget.

Each of the cutbacks undermines the health of local populations but also increases the longer-term burden on the NHS and other public services.

Poorest cut hardest

But the IPPR points out that the heaviest cuts have fallen on the areas of highest need and deprivation. Fifteen percent of all cuts (almost £1 in every £7) have hit just 7 percent of local government areas – the most deprived ten places.

These poorest areas "have lost approximately 35p in every £1 of their budget" for public health, and the cutbacks in these areas have been far higher on key services such as the national child measurement programme, obesity, drug and alcohol, and smoking, while one of the few services to be increasing nationally, physical activity, is far better resourced in the richest areas (up 76%) compared to the 9% increase in the most deprived areas.

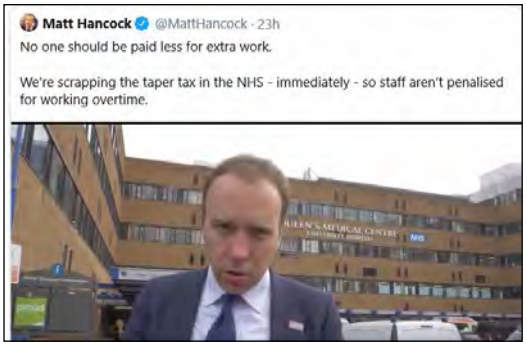
Theresa May's government agreed a one-off 1 percent increase in public health funding, well short of the £1 billion the IPPR calculates is needed to restore it to the 2014 level. Without real resources to address public health problems, any talk of "one nation" policies is a wilful deception.

Short term fix does not end pension tax fiasco

Matt Hancock may claim that the flawed "taper tax" on pensions affecting senior NHS consultants has been "scrapped immediately" – but this is flatly contradicted by the statements of NHS England and well-informed reporters.

The tax remains firmly in place, but NHS bosses and the government have bodged together a temporary fix. According to NHS England boss Simon Stevens "a substantive answer from Government to the tapered annual allowance issue now seems unlikely to take effect before the new tax year, from April 2020."

The Health Service Journal sums up: "A temporary 'solution' to the pensions tax impact on the health service has been confirmed by NHS England and signed off by government. … This stop-gap solution comes amid huge concern about senior doctors turning down additional shifts, because of the threat of large tax bills on their pensions."



However the HSJ points out that it's still not clear where the funding will come from to refund the tax payments that would initially be taken from consultants' individual pension pots, and refunded on retirement.

The Guardian notes that it is being presented as an "operational decision" by NHS England, to avoid criticism that it breaches "purdah" restrictions on new policy, "but was signed off – and some believe instigated – by the Treasury, Cabinet Office and the Department of Health and Social Care."

The lie that keeps on coming: claim to be building 40 hospitals

Matt Hancock, Michael Gove and others have been travelling the country repeating the claim that the Johnson government has launched "the largest hospital building plan in a generation, with 40 new hospitals across the country."

In fact all the Johnson government has done is provide £2.7 billion to fund just SIX new or refurbished hospital projects.

£100 million is also provided as "seed funding" for 21 trusts to draw up plans for another 34 hospital projects – which will potentially cost another £10 billion or more – after 2025.

By comparison from 1997-2010 Tony Blair's government built well over 100 new hospitals – albeit funded through PFI.

It's also questionable whether the 34 future projects will ever get beyond the planning stage, since they would need to be agreed and funded by a future government after at least one further election, during or after 2025.

None of the six new hospitals that have been given the "immediate" go-ahead is ready to start work for many months yet. In some cases it's already clear that the amount of capital allocated falls short of the amount needed.

The lie that EU nationals working here don't pay tax

Claim: "It's unfair that people coming from European countries can access free NHS care without paying in while others make significant contributions." - Michael Gove, Mail on Sunday, Nov 17

Gove's claim has been angrily rejected. Nicolas Hatton, the co-founder of EU citizens' rights group the3million, told the Guardian: "It's a cheap political ploy based on xenophobia designed to get votes."

"EU citizens do not have automatic rights to health systems in EU states," he said.

"In the first three months, you are treated like a tourist with no rights, and after three months, unless you are working or are self-sufficient, then you have no rights to the NHS."

Labour MEP Claude Moraes said "The line that Gove used about 'paying into' the NHS is really an old-style racist trope and is designed to target Labour marginals where the vote is about leave or remain. You can't "pay into the NHS" even if you wanted to."

Shadow home secretary Diane Abbott also intervened on Twitter to argue:

"Michael Gove is completely wrong to say people from EU are accessing the NHS without 'paying in'.

"EU workers pay taxes. The NHS is not a contributory system.

The government's own Migration Advisory Committee report in 2018 concluded "There is no doubt that EEA migrants contribute more to the health workforce than they consume in healthcare. This can be explained by their age profiles, they tend to be younger than the make-up of the resident population."

The lie that the NHS would be off the table in any future US trade talks

US President Donald Trump stated clearly during his visit to England in June this year that the NHS and its £120bn budget should be "on the table" in any trade talks.

Subsequent efforts by PM Johnson and his ministers to undo the electoral damage that this could cause among their own supporters have relied on us accepting Johnson's own assurances and the attempt by Trump the following day to tone down what he had said.

But can Johnson's protestations be taken seriously? It's clear from a Times report back in September 2018 that the "Initiative for Free Trade", a right wing "think tank" closely linked with senior Conservatives (former ministers Liam Fox, David Davis, along with ERG chair Steve Baker and Tory MEP Daniel Hannan, has explicitly called for the NHS to open up contracts to run NHS hospitals to US corporations.

Now the Led By Donkeys campaign has unearthed evidence including video footage of the launch of this IFT report, and confirmed that it was hosted by Boris Johnson in the map room of the Foreign Office, with taxpayers picking up the tab for the £6,000 event. There is footage of Johnson himself introducing it as a "crucial" event and seated as the proposals were unveiled.

Since then Jeremy Corbyn has confronted Johnson with the leaked document proving that preliminary discussions on "full market access" to the NHS have already been held with US trade representatives. It seems the more they deny involvement the less credible they become.

Staffing crisis puts patients at risk

Tackling the growing NHS staffing crisis is ranked as a key priority for the next government by 94% of hospital chief executives and chairs, with more than half putting the issue as number one on their list, according to a new survey by the NHS Confederation.

More than nine out of ten senior managers (91%) agreed or strongly agreed with the statement 'understaffing across the NHS is putting patient safety and care at risk.

Vacancies

The NHS Confed repeats widely-shared estimates that there are more than 100,000 FTE vacancies in England in hospital and community services alone, and emphasises that the problem has been mounting over the past five years:

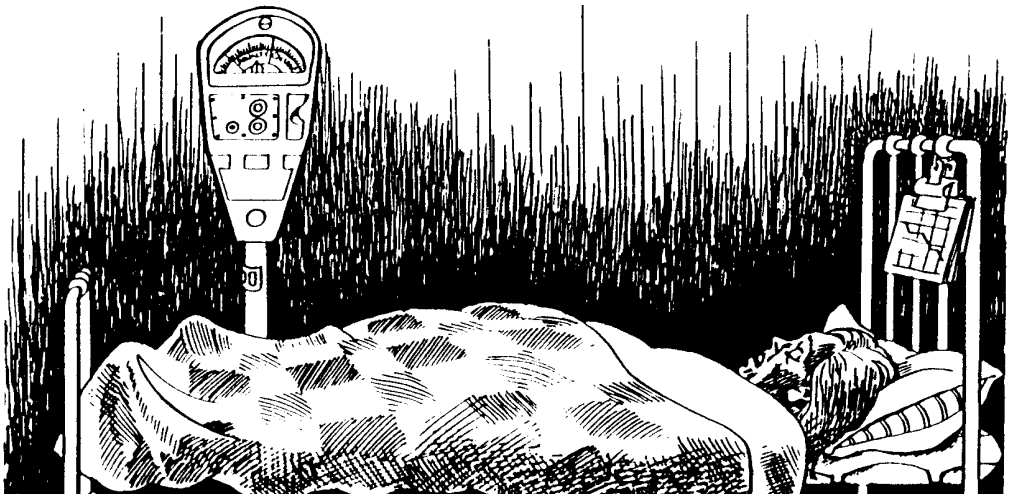
"In every month from 2014 to 2019 most hospitals were only able to fill their shifts using temporary and agency staff. This shortage is particularly pronounced in mental health and learning disabilities services, which have a disproportionately high number of vacancies."

The report also points to a slightly larger number of vacancies in social care, with around 122,000 vacancies: "around one in ten social worker roles and one in 11 care worker roles vacant."

The Confed warns that a no-deal Brexit poses risks when it comes to recruiting and retaining staff for the NHS and social care. 65,000 NHS staff, over 5% of the workforce in the English NHS, are EU nationals. And there is a warning as Tory ministers prepare to charge for visas and access to the NHS for future staff from EU countries after Brexit:

"Given the current shortfalls, it will be vital to enable and encourage overseas staff who want to come to work here and make sure they have the means to do so easily and with confidence about their future status.

"Whatever happens with Brexit, future immigration policy must take into account the staffing needs of both the health and care systems."



Private hospital chiefs stung by threat to their NHS income

John Lister

The Labour Party's promise to "end and reverse privatisation in the NHS in the next Parliament" has triggered a tetchy response from the private hospital chains, which have been doing good business and filling their otherwise empty beds with NHS-funded patients

The Independent Healthcare Providers Network (IHPN) claimed (perhaps having just listened to Boris Johnson's inflated promises) that "over 40" new NHS hospitals would be needed if a Labour government prevented private hospitals from delivering care for NHS patients, and warned that waiting lists for specialist care could treble in three years.

They went on to claim the private sector performed 11.2% of all non-urgent care, which they say was 436,000 operations a year. The IHPN's chief executive David Hare argued that this proved the "vital role" private providers play.

NHS trained staff

However the boot is on the other foot. Without the medical, nursing and professional staff trained and largely employed by the NHS when not doing shifts in private hospitals, and the availability of NHS emergency and intensive care facilities for the cases that go wrong, the private hospital sector would collapse.

Indeed the more the private sector expands, the more they tend to poach further scarce NHS staff, and put greater pressure on NHS hospitals which are responsible for the full range of health services.

However their calculations seem wide of the mark in almost every respect.

According to the main market analysts Laing & Buisson, there are **197** private hospitals licensed to take acute patients, with 9872 beds between them, **averaging just 50 beds** per hospital: this underlines how limited is the range of services the private sector is set up to deal with, with no emergencies to deal with.

9872 beds is the equivalent of around **20 district general hospitals** with 500 beds – not 40. But since many of the private sector hospital beds are under-occupied and providing only a limited range of elective procedures it's not at all obvious they would all need to be replaced.

By contrast the NHS has just over 100,000 general and acute beds, mostly in full service general hospitals.

Mental health

The situation is very different in mental health, where the private sector expansion has been the greatest.

Laing & Buisson estimate there are 8942 private beds funded by the NHS, but give an inflated figure of 23,596 public sector beds: in fact the latest NHS figures show just 18,179 mental health beds after a decade of cutbacks, so the private sector is currently providing around a third of mental health in-patient capacity, much of this through companies that are now owned by US corporations.

However the IHPN is not concerned with mental health: its focus is on acute care, and here too there numbers are questionable, and the basis on which they have made their calculations is not explained.

The NHS in England delivered **8.8 million elective admissions** in 2018-19: so 436,000 operations is not equivalent to 11.2% of all non-urgent care, but **just under 5%**.

Private sector apologists also argue that private hospitals are only paid the standard NHS tariff for the publicly-funded patients they treat – but they don't do the standard type of NHS work. They take a very different, more restricted caseload, accepting only the least complex or risky cases, while the NHS has to accept all comers.

It's high time there was a real audit of the costs – overt and hidden – of the private sector: if there was, the IHPN would have to come up with some more plausible figures.

Surcharge to be increased to £625

Ministers inveil new plans to deter health workers from coming to Britain

John Lister

The *Daily Mail* could barely conceal its joy as Tory ministers spelled out new ways in which a re-elected Johnson government would "get tough on post Brexit migrants" – and jack up the "Immigration Health Surcharge" (HIS) from £400 to at least £625 per person.

This is just one of a nasty "battery of measures" to delight the immigrant-hating *Daily Mail,* but of course it would be additional deterrent to any potential health professionals who might consider coming to work for our NHS, including some of those who until the Brexit vote were coming in numbers from the EU:

"after Brexit, all foreign patients – including those from the EU – will have to pay a £625 fee, which is expected to raise an extra £500 million a year for the NHS."

Half price visa

It was only a couple of weeks ago Johnson announced that health workers would be encouraged to come to Britain by a special half-price visa (although, as we explained in our last issue, for EU nationals it is not a halving of price, but a new imposition of a £464 fee).

The 50%-plus increase in the IHS, pushing the up-front cost of coming here to more than £1,000 in addition to regular taxes is an added deterrent, despite the desperate staffing shortages in the NHS.

The latest increase in charges is the outcome of a relentless campaign by the *Daily Mail* and other right wing newspapers, which have peddled the myth of "health tourism", and hugely inflated the costs of treating the small numbers of overseas visitors who make use of NHS treatment.

In October the *Mail* headlined a largely fictitious "calculation" by unnamed Department of Health bureaucrats, which claimed that the IHS had been set too low at £400 because "Each payer of the IHS ends up costing the NHS an average of £625 a year."

In 2018 Immigration Minister Caroline Nokes claimed that the health department had been modelling the costs incurred by IHS payers and estimated it as averaging £470.

Now the *Daily Mail* is quoting new figures, allegedly "based on actual usage by IHS payers", showing that, on average, each IHS payer cost £631: "£88 in GP appointments, £35 in dental and eye care, £55 in prescriptions, £237 in hospital care including A&E, and £216 in other costs, including ambulance services, mental health and administration."

The document containing these imaginary figures has of course not been published, nor has any explanation been offered of its completely implausible assumptions on the scale of use of the NHS by migrants.

Not only do migrant workers who pay the surcharge also pay the same level of income tax and other taxes which fund the NHS, but there is evidence showing that migrants often use the NHS less than native populations:

"People who migrate tend to be younger and healthier than native populations. Older people and those with disabilities and severe illness are less likely to move, apart from in extreme circumstances. This underpins a longstanding epidemiological phenomenon, called the "healthy migrant effect"

The King's Fund argues that "The average use of health services by immigrants and visitors appears to be lower than that of people born in the United Kingdom, which may be partly due to the fact immigrants and visitors are, on average, younger."

The Health Foundation points out that: "'Migrants are good for the NHS. Existing evidence shows that immigration makes a positive contribution to the UK health service. Migrants contribute through tax, tend to use fewer health services compared to others, and provide vital services through working in the NHS."

Sadly such evidence is unlikely to deter Tory ministers seeking votes by playing up the prejudices and ignorance of racists or the Daily Mail playing to its most xenophobic readers.

Ambulances queued outside Peterborough City Hospital - photo Peterborough Live

Pre-winter crisis in A&E

As performance levels of acute trusts plummets and the winter draws near, with no additional winter funding made available to trusts this year by NHS England, the relatively new PFI-funded Peterborough City Hospital is giving cause for concern.

Delays of up to 6 hours in transferring emergency patients from ambulances in to the Emergency department have been reported to the local newspaper.

The percentage of A&E patients treated, discharged or admitted within the target 4 hours has fallen from 92.6 a year ago to just 75.8 in October, while the number of hours ambulances have been stuck outside the hospital unable to hand over patients has almost trebled from 312 to 886 in the same period.

Worryingly the latest A&E performance figures indicate that these are far from the worst-performing trusts in England: on the October figures the bottom of the heap for treating the most serious Type 1 A&E cases within 4 hours is **Lancashire Teaching Hospitals**, bumping along at less than half the target percentage of 95%: **eight more** trusts are scoring below 60%.

The bottom ten performing trusts include **Hillingdon Hospital**, local to Boris Johnson's constituency. He will no doubt be hoping his constituents remain unaware of this failure so close to home.

Ten trusts with longest waits for Type 1 A&E in October 2019	% within 4 hours (target 95%)
Lancashire Teaching Hospitals FT	**46.7**
Blackpool Teaching Hospitals FT	**52.7**
Barking Havering & Redbridge	**53.3**
United Hospitals Lincolnshire	**56.7**
Shrewsbury & Telford	**57.9**
King's College Hospital FT	**59.3**
Norfolk & Norwich Hospital FT	**59.3**
Croydon Health Services	**59.6**
Wirral Teaching Hospitals FT	**60.4**
Hillingdon Hospital FT	**60.6**

A&E Attendances & Emergency Admission monthly statistics, by Provider, October 2019

Simon Stevens: five years of failure that have plunged NHS into growing chaos

John Lister

The latest, shocking statistics showing the scale of the decline of NHS performance on almost all of its key targets raise serious questions, not only about the need for more staff and more funding to run services and invest in new and improved buildings and new equipment, but also about the senior management of NHS England and its chief executive Simon Stevens.

The priorities, policies and attitude to staff and to public accountability of Stevens and the team around him have shaped the service, and must be seen as partly responsible for the decline in performance of NHS services.

They must also share the responsibility for the grim revelations of the scandals of mistreatment of maternity cases in Shrewsbury and Telford Hospitals Trust, which seem certain to reach a scale far worse than the previous worst maternity scandal at Morecambe Bay, and eclipse the scale and severity of the Mid Staffordshire Hospitals scandal in the mid 2000s.

If Stevens had performed on a similar level as manager of a Premier League football team or many private businesses he would have been out on his ear several years ago.

It's now more than five years since Stevens, a former Labour councillor and advisor to Tony Blair's government, took over at NHS England after working nine years as a vice president of US health insurance giant United Health. Six months later he published a major policy document, the Five Year Forward View (FYFV).

Looking back at the 44-page FYFV is like stepping into a museum: most of the key commitments have long ago been sidelined or reduced to token gestures, not least the insistence that:

"The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."

But while the plan presumed improved public health, since 2014 we have seen year after year of cuts to public health budgets which are supposed to fund schemes to help tackle obesity and reduce consumption of alcohol, drugs, and tobacco. This is not Stevens' fault: but what is his fault is that his plan rested on such unrealistic assumptions.

Main ideas

Many of the main FYFV ideas, whether people agreed with them or not, have also remained little more than words. For instance patients were to be given control over shared budgets for health and social care – a controversial idea with many campaigners, and one which lacks sound evidence that it can work in the NHS. Stevens in a July speech in 2014 suggested "north of 5 million" such personal budgets might be operational by 2018, sharing £5 billion between them.

But this apparently bold proposal, if funded at that level, would have meant average payments of just £1,000 per year, £20 per week – well short of the amount

required to secure any meaningful care package for any but the most minor health needs – even if the services required were available, and the patient/client was confident enough and able to sort out their own care.

Moreover the latest figures show that the vision was unrealistic on almost every level: the number of personal health budgets has apparently been rising each year since they launched in 2014, but there were fewer than 23,000 people receiving one in the first nine months of 2017/18 – a long way short of 5 million.

Carers, too, were promised new support by the FYFV (not for the first time, and no doubt not for the last). Yet the plight of carers remains desperate, with increased misery for many of them hit by the succession of welfare cuts and the nightmare of universal credit.

Barriers

According to the FYFV, barriers between GPs and hospitals, physical and mental health and health and social care were going to be broken down.

A "Forward View" for GPs has since been published: but there was also supposed to be a shift of investment from secondary care into primary care, which has not happened (how many times have governments proposed that since the 1980s?).

So barriers are still intact. Overworked, under-staffed GPs face ever-increasing demands, with no sign of the promised increase in numbers or resources; in frustration they are now calling for an end to the requirement to do home visits.

The FYFV also made bold promises to invest in more staff and improved services for mental health. Predictably none of these things have happened. Instead there are still thousands fewer mental health nursing staff now than there were in 2010, and the performance on almost every measure is as bad or worse than 2014.

It also went on to propose new "models of care", including Primary and Acute Care services (PACS).

Stevens compared these with "Accountable Care Organisations that are emerging in Spain, the United

States, Singapore, and a number of other countries."

Given his previous employment, this understandably led to widespread fears of 'Americanisation' – despite the fact that few such organisations have been proposed here, and even fewer launched, none of them involving private companies.

Long Term Plan

After such a comprehensive failure to deliver almost any significant element of the FYFV, the likelihood of making the TEN year Long Term Plan (LTP), published back in January, any more than a wish list or a pious declaration seems to be vanishingly small.

The Long Term Plan does contain a few positive concessions to the pressure of campaigners and the needs of patients:

- New waiting time targets are to be introduced for adult and child mental health – although these are far from ambitious and without extra funding imply cutbacks elsewhere;
- A promise of action to address unexplained mortality for people with learning disability and autism and the long waits they experience;
- No explicit call to close acute hospital beds;
- The idea is floated that the NHS take back responsibility for some public health provision.

These few positive elements must not distract us from the hard proposals in the LTP for a further top-down reorganisation of England's NHS – into a centralised structure of 44 "Integrated Care Systems" (ICSs) which are to "grow out of the current network of Sustainability and Transformation Partnerships" (STPs) within two years.

They are to be policed by regional directors and a network of 'joint NHS England and NHS Improvement regional directorates' announced in November. That's the meat of the Plan.

As proposed in the LTP, none of these new structures will be in any way accountable to the local people and communities they cover.

Each ICS would work to an 'Integrated Provider Contract' – along the lines proposed by NHS England in 2018, and opposed by many campaigners. Once again there is no guarantee that the new contracts could not be sub-contracted to the private sector.

The Plan also requires a series of mergers to reduce from 191 Clinical Commissioning Groups to just ONE CCG per ICS. The remaining CCGs are also required to cut their management costs by another 20%, ensuring they are reduced to rump bodies with residual token power, in practice accountable to nobody. Trusts, too, would be required to collaborate with the wider ICSs.

With local authorities once again not even consulted on the Plan, it's clear that just like the "Sustainability and Transformation Plans" that were hatched up in secret in 2016, none of the Plan would be subject to any consultation with staff, the public, or anyone else.

CCGs and trusts with the toughest financial problems, and often with the most inadequate resources, face the hardest targets and the harshest treatment.

Private hospitals

Tucked away in the Plan are more hard-edged proposals for increased use of private hospitals to deliver NHS funded care to limit waiting times (already being surreptitiously driven through by NHS England), as well as new pressure on trusts to increase their links with the private sector to "grow their external (non-NHS) income" and "work towards securing the benchmarked potential for commercial income growth."

There also is an implicit threat of privatisation in the LTP proposals for new pathology networks and imaging networks to be established, in the absence of the necessary NHS capital for investment.

Trusts are told they must also aim to increase the funds they get from charging patients for treatment – "overseas visitor cost recovery" – a policy which will raise little money in relative terms, but which will deter some patients from accessing the services they need, undermines the principles and values of the NHS, and which is opposed by the medical Royal Colleges.

CCGs and trusts with the toughest financial problems, and often with the most inadequate resources, face the hardest targets and the harshest treatment.

The Operational Planning and Contracting document, published on December 21 2018 (and subsequently re-issued in January 2019) set out proposals for "savings" of more than £200m a year to be delivered from restrictions on GPs prescribing a growing list of drugs and treatments.

Some CCGs have already gone well beyond the initial list of exclusions drawn up by NHS England, and in a number of cases the private sector is eagerly lining up to offer to sell patients the operations and treatments they can no longer routinely get on the NHS.

To sugar the pill, the Long Term Plan has to say something and so it rattles out upwards of 60 uncosted commitments to improve, expand or establish new services. Most of them, if taken at face value would be most welcome – but taken together in this context they

continued page 10

Five years of failure

... continued from pages 8-9

are completely unaffordable, unrealistic and incapable of implementation.

There is promise after promise, many of them sounding great: prompt response services, proactive care, flexible teams, neighbourhood teams, primary and community care teams, community multidisciplinary teams and upgraded support. All these are presented in happy-clappy, completely abstract terms, without explaining how they were chosen, who would be responsible, or the timescale for implementation.

The Plan insists on a 'digital first' option for most consultations in ten years, a vision of future services that many patients would view with trepidation:

The obsession with digital access runs as a theme through the Plan, and ignores recent research that showed Skype-type online consultations are suitable for only small minority (2-22%) of hospital outpatients, with many clinics finding them completely impractical.

There is growing evidence of the weaknesses and limitations of the much vaunted "Artificial Intelligence" chatbot produced by Babylon, and similar digital innovations lack evidence they are effective, or cost effective.

Fatal omissions

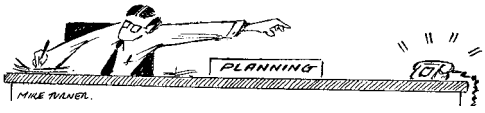
Of course it's impossible to discuss the LTP's content without also addressing the vital issues that are omitted from it. An enormous number of major issues are either ignored completely or blithely brushed aside in the 136-page Plan.

These include the declining actual performance of trusts; the inexorable rise in emergency caseload; the insufficient capacity in acute and mental health services and bed shortages; the £6.6 billion and rising bill for backlog maintenance; the cuts inflicted in mental health and community services; the impact of repeated cuts in public health budgets; the widening gap in society between rich and poor and the resultant inequalities in health – exacerbated by unchanged austerity and reactionary government policies on housing, welfare, education, and local government:

and of course the gathering crisis of a dysfunctional social care system, for which the long-promised Green Paper has repeatedly been postponed.

No serious workforce plan has yet been published, and there is no evidence work on this has advanced at all; and there is clearly not enough money in the pot to pay for significant new ideas, or the extra staff that are needed.

An enormous number of major issues are either ignored completely or blithely brushed aside in the 136-page Long Term Plan.



NHS England has also turned a blind eye to efforts by hospital trusts to dodge VAT and other taxes by transferring their own support staff against their will into wholly owned companies outside the NHS – thereby undermining the integrity of the existing workforce and quality of services (see page 11 opposite).

Funding gap

Every informed observer has warned that the famous £20.5 billion real terms "extra" funding over five years repeatedly announced since last summer [and now misleadingly rebadged by PM Johnson as a **£33.9bn** increase in cash terms] is not enough to do much more than slow the decline and keep the lights on.

It's clear that with the financial constraints limiting any real improvement, and a new system being imposed from top down and accountable only upwards to NHS England, patients and the public will have less voice and influence than ever in the shape of services and their access to them. Everything about us would be decided without us.

The Long Term Plan is a medium term threat to the services we all depend upon – and our ability to find out what's happening and fight back locally to defend the services we need.

There has been damaging privatisation, with plans for more, but so far US health corporations have made no real attempt to exploit the market established by the 2012 Health and Social Care Act to win contracts to deliver health care, hospital services or even health insurance in England.

They remain largely on the sidelines, seeking lucrative but relatively small scale back office roles in the NHS. If Simon Stevens is, as some believe, their Trojan Horse, their inside route to fully "Americanise" the NHS, there is little sign the conspiracy is succeeding.

Rather than focusing on how Simon Stevens is promoting US corporate interests we need to expose the many flaws inherent in his "reforms" and organisational changes since 2014. These changes have been:

- Outside the law, and therefore lacking, and avoiding, any proper scrutiny by parliament, local government or local people.
- Centred on creating local and regional level organisations which also lack any accountability to local communities
- Aimed at centralising services, at the expense of closures and downgrades of local A&E and other services, while lacking the capital to provide or expand alternative services
- Focused on inappropriate and ineffective US-style "integrated care" despite the lack of evidence this can really integrate services, limit demand for care, or deliver any significant benefit to patients.

Stevens and NHS England have ignored the continually worsening performance being delivered month after month by underfunded, overstretched and under staffed hospitals and mental health services.

The changes it has driven through are increasingly jeopardising patients' lives by putting front line staff under impossible pressure and worsening the recruitment and retention of staff vital to quality care.

The pattern has been one of consistent failure masked by the rhetoric of grand, impractical plans, few of which have been carried through.

It's time Mr Stevens was properly called to account, by a government that values the NHS.

Bradford strikers defeat privatisation

The Bradford Hospital strikers, who staged lively three weeks of strike action this summer, have won their fight to force the trust to drop plans to forcibly transfer them into a newly-created "wholly-owned subsidiary company" – Bradford Healthcare Facilities Management Ltd (BHFML).

Over 300 UNISON members, including domestics, porters and security staff, were determined throughout to retain their status as NHS employees and not to be dumped into the private sector as part of a bid to cut VAT and other tax costs.

They initially took one week of strike action, followed by a 2-week stoppage in August when management refused to budge: an all-out stoppage that had been unanimously agreed was suspended at the end of August to allow talks to take place.

Three months later these have eventually secured a decision of the Trust not to continue with plans to create a new company. All staff employed within Estates, Facilities and Clinical Engineering will remain directly employed by the Trust.

Commenting on the Trust's climbdown, UNISON general secretary Dave Prentis said: "It is time for NHS Improvement to stop trusts going ahead with these projects without staff support. This case sends a strong signal that the practice of creating subsidiary companies should be brought to an end completely."

The Trust had denied it was privatising services, insisting that the development of the new company was "essential." Even now it has been scrapped, Trust Chief Executive Mel Pickup said: "The reasons for seeking to set up the new company have not changed."

"We now must work together with staff and UNISON to find alternative ways to make productivity gains within these important support services."

■ A UNISON commissioned opinion poll early in November found a majority of the public opposed to transferring NHS staff to private contractors.

The UNISON/ComRes poll also found the vast majority (78%) of people believe non-medical employees are just as important to the health service as staff who deliver treatment such as doctors, nurses and midwives.

Frimley trust halts WOS plan

Plans for around 1,000 support staff at Frimley Health Foundation Trust's three hospitals – Frimley Park, Heatherwood and Wexham Park – to be transferred out of the NHS into a new wholly owned subsidiary (WOS) have been halted by the threat of a planned coordinated 48-hour strike by all three major unions.

At the last minute an agreement was secured over the weekend by UNISON, which represents the majority of porters, security guards, cleaners and catering staff employed by the Trust. The Trust gave a commitment not to continue with its existing plans while other options are pursued, including possible ways to keep the staff employed within the NHS. In view of this UNISON agreed to take no further action for the time being.

■ The other two unions, Unite, with 90 of its members at the Trust working in estates' management, equipment maintenance, catering, portering, procurement and security having voted 92% for strike action, and the GMB which had "drawn a line in the sand" against the WOS, went ahead with their action and public protests on November 18-19.

Warnings of the "technological wild west"

John Lister

Matt Hancock and NHS England are not the only eager advocates of digital technologies.

In June this year WHO Director-General Dr. Tedros Adhanom Ghebreyesus argued that "harnessing the power of digital technologies is essential for achieving universal health coverage."

However a Tek4HealthEquity conference in New York early in November has served to flag up some dangers that the fans of digital solutions are keen to bush aside.

A report from this conference by the Antwerp-based International Health Policies Network (IHP Network) warns that "rampant commercialisation and weak regulation challenge the ideal of digital public goods capable of reducing inequalities."

The authors point out that enthusiasm for digital health solutions reflects the broader technological optimism that has long characterised the global health field.

But it is "founded in the belief that market-based solutions and innovation-driven development will produce cost-effective solutions to solve the world's problems."

Discriminatory

They report that presentations at the conference highlighted "discriminatory design, high costs and weak regulations" as some of the challenges to the idea of digital public goods capable of reducing global and national-level inequities in health.

The conference's starting point was that digital technology is not neutral, "but is developed and deployed in specific social and political contexts, and is therefore susceptible to built-in biases, which can become embedded in the technology itself."

"A study recently published in Science revealed that an algorithm used by American hospitals and insurance companies to enable treatment that is more efficient systematically discriminates against black patients."

And "while commercial actors often reap heavy rewards, the solutions are not necessarily cost-effective for public authorities, nor do they always have proven health benefits."

Health care is facing a "technological wild west" in which ownership is concentrated among a few, dominant tech companies like Google, Facebook and Amazon combined with non-existing or inadequate legal and regulatory frameworks.

As a result, the authors argue "Before we conclude that digitalization benefits vulnerable individuals and accelerates improvements in global health equity, we need a closer look at which kinds of technologies are developed, for whom and with what purpose."

THE lowdown

Health news, analysis and campaigns.
NUMBER 15, December 9 2019

Informing, alerting and empowering NHS staff and campaigners

Hidden costs will weigh down six trusts that get new hospitals

Unite has hailed victory in the long-running Lincolnshire health visitors' dispute, which is coming to an end with the vast majority of the workforce being upgraded onto the grade 10 pay scale.

John Lister

The infamous promise of "40 new hospitals" by Prime Minister Boris Johnson has not only been shown to be misleading, but the six trusts that will get new hospitals will be saddled with hefty extra payments.

Even though the extravagant rip-off funding through PFI has now been brought to a halt, trusts will have to pay an annual "dividend" payment of 3.5 percent each year for the capital investment they receive and on the increased value of their assets, according to a Health Service Journal report.

Although there would be no requirement to pay back the initial funding, the 3.5% payments would continue indefinitely as an added financial burden to the trust.

The £2.7 billion that will be allocated to the six trusts for rebuilding and upgrading their hospitals is part of a £3 billion "health infrastructure plan". But far from being generous, it is less than a third of the £10 billion called for in the Naylor review of estates two years ago.

Meanwhile the 21 trusts planning 34 new hospitals (including a number of community hospitals with few if any acute beds) get to share £100m of "seed funding," and offered only the vague hope that their business plans might be accepted some time after 2025.

£20m per year interest payments

The increased costs facing trusts can be considerable: the *HSJ* takes the example of the West Hertfordshire Hospitals Trust, which is seeking around £400m to rebuild its crumbling general hospital in Watford, despite complaints from elsewhere in the area that the site is inaccessible.

The trust has told staff that **"The money is not a free gift but is a bit like an 'interest only mortgage' — we will make an annual dividend payment on the sum provided but we won't be asked to repay the principle sum. The extra cost pressure due to capital charges would be around £20m per year."**

Nuffield Trust analyst Sally Gainsbury told the HSJ: "While 3.5 per cent looks high compared to prevailing interest rates at present, a more significant problem is the fact provider incomes have become so squeezed that many already struggle to cover their staff costs, let alone generate a return on their physical assets to reflect the costs of that investment."

The West Herts Trust has a backlog maintenance bill of £65m, and already has to pay interest on £195m of government loans accumulated over recent years to prop up its flagging budget, and is struggling to meet a target of reducing its deficit this year to £27m.

An extra requirement to find at least £20m per year is likely to force more desperate cost-cutting measures, even when the new building is eventually opened.

"The money is not a free gift but is a bit like an 'interest only mortgage' … The extra cost pressure due to capital charges would be around £20m per year."

Backlog and borrowing

Of the other trusts promised new hospitals, Barts Health already has accumulated loans of £149m and a £65m deficit; Leeds Teaching Hospitals has a relatively small deficit but £89m of loans; Princess Alexandra Hospital in Harlow has £66m of loans and is projecting a deficit of £27m; University Hospitals Leicester has a massive £209m of loans already in place, and expects to meet its control total deficit of £49m. So none are strongly placed to pay out the additional costs of the new buildings.

Senior policy adviser at NHS Providers, David Williams, told the HSJ:

"This shows that capital and revenue are closely related, not isolated funding streams. Trusts need both adequate, multiyear capital investment and sustainable revenue settlements to maintain services at the appropriate standard."

IN THIS 16-PAGE THIRD PRE-ELECTION, END OF YEAR ISSUE

NHS is on the table!

Leaked documents confirm NHS has been on agenda of US trade talks

John Lister

Drug prices, and the length of patent protection that keeps the price of branded drugs high, have been at the centre of a series of meetings between British and US trade delegations as Theresa May's government began preparations for a US trade deal after Brexit.

451 pages of official British government notes revealing this and other aspects of the discussions were leaked to the Labour Party last week.

They led to reinforced accusations by Jeremy Corbyn and other Labour leaders that (as Donald Trump had said on his visit to Britain in the summer), the NHS was "on the table" in trade talks. Corbyn has argued that ministers had been discussing "selling it off" to the Americans.

The *Daily Mirror* took a similar view, describing "a bombshell press conference" in which "Mr Corbyn first showed heavily-redacted government documents, obtained by campaigners, relating to months of trade talks between the US and the UK. But he then dramatically held up a second bundle - the uncensored versions."

The *Guardian* reported Labour's argument that "We have now got evidence that under Boris Johnson the NHS is on the table and will be up for sale. He tried to cover it up in a secret agenda and today it has been exposed."

The current government may have tried to suppress the embarrassing content, but attempts to question whether the documents were genuine were derailed when former minister Liam Fox, who was present at the early meetings, confirmed they were.

The documents span a period before Johnson took office, and the *Financial Times* among others was keen to play down their significance. Their correspondent Jim Pickard argued that out of the 451 pages there only seemed to be a few relevant paragraphs:

"On page 41 it says that the US is not keen on warning labels on food.

"On page 43 it repeats the US desire to improve the "media narrative" on chlorine-washed chicken.

"On page 119 there are some words hinting at the US desire for longer drug patents.

"That's pretty much it....quite thin material when you boil it down to the essentials."

So what are we to make of the evidence, now we can now comb through it online?

Missing out on content

It's clear the *FT* missed a lot of interesting content. In the first meeting (page 24) there is a discussion of the movement of professionals across borders and recognition of their qualifications – and this includes nursing:

"Nursing was the other profession that the US was interested in. Nursing in the US was very closely coordinated with Canada and Ireland. The relationship with Canada was particularly close and Canada had adopted the US exam. A compact between 25-30 states meant that nurses were able to move between those states. The US were interested to know if it would be really problematic for the UK to act in this area – they were sensitive to the particular sensitivities with the health sector in the UK."

In the second meeting the US ambition to lengthen the life of patents that protect the higher prices of branded drugs was discussed:

"The US said there is a lot of conversation on drug prices and looking at what other countries pay and this is causing angst. There are worries that the US is not getting a good deal in pharmaceutical industries." (pp48-49)

State Owned Enterprises

In the third meeting the discussion moved on to a discussion of State Owned Enterprises (SOEs), in which the US trade delegation "probed UK position on our 'health insurance' system" (p49).

While it's clear the main US concerns in this regard are with the many large SOEs in China, the discussion clearly shows a determination to restrict the freedom of governments to protect or subsidise these enterprises:

"The US tends to be more aggressive in trying to discipline other nations' subsidy programmes. The US business community became interested in SOEs a few years ago, which drove this position further. The US stated that SOEs are particularly positioned to potentially disrupt trade flows, and so are keen to have tougher rules for SOEs than for private business." (p50)

It's interesting that in this discussion the US asked if the UK had concerns about their "health insurance system."

The British did not point out that the NHS is not an insurance system, but a health service funded from taxation. Nor did they insist it had to be off the table. Instead they replied that more discussion should take place 'further down the line':

"the UK has an advanced competition law regime and strong corporate governance rules, and we believe we are compliant with international best practice. Wouldn't want to discuss particular health care entities at this time, you'll be aware of certain statements saying we need to protect our needs; this would be something to discuss further down the line when we come to consider what entities would count as 'enterprises'. (p52)

"The query about 'health insurance' was likely a fishing expedition to check the tone of our response."

The Lead Negotiator comments on this query, noting that:

"The query about 'health insurance' was likely a fishing expedition to check the tone of our response. We do not currently believe the US has a major offensive interest in this space – not through the SOE chapter at least. Our response dealt with this for now, but we will need to be able to go into more detail about the functioning of the NHS and our views on whether or not it is engaged in commercial activities …" (p53)

Extending patent protection of profits

The Fourth meeting included a lengthy discussion of patent issues. The document flags up as "Key Points to Note" the connection with the NHS:

"This session provided the UK with an opportunity to provide a comprehensive overview of our approach to patent policy and highlight how this is intricately linked to the UK health system." (p119)

An introduction from the UK delegation argues:

"The pharmaceutical sector has an annual turnover of £48.2 billion, it employs over 100,000 people from 2,000 businesses, and it is closely integrated with the UK's national health system." (p121)

The discussion on how the two systems work concluded with an upbeat suggestion that agreement is getting close:

"We have reached a point (for Patents in Pharmaceuticals/Health) where beyond specific policy details in niche areas, we are awaiting the clearance to negotiate and exchange text to really take significant further steps. There is however significant scope to discuss patents in other areas at future sessions, in particular: Technology and Agriculture/Chemicals." (p132)

Data and algorithms

In addition, as the *Times* has pointed out, the leaked documents, most especially from the fourth meeting in July 2018, also revealed that a "top priority" of US negotiators was establishing a "free flow" of data (p22), and emphasising US opposition to any requirement for American companies to disclose encryption methods or algorithms underlying their systems.

Alan Winters, director of the Trade Policy Observatory at Sussex University, told *The Times* that clauses on data sharing and algorithms that US negotiators want inserted into a deal could be used to capture data from Britain's 55 million NHS patient records, which city accountants EY have estimated could be worth £10 billion a year.

According to the Times report:

"The arrangements could see UK data swept back to servers in America and mined by algorithms written in Silicon Valley to develop new diagnostic tools and medical devices that would then be sold back to the NHS."

The UK NHS could wind up "unable to analyse its health data without paying a royalty to Silicon Valley to use an algorithm," and "Once the algorithm has been written and copyrighted by an American company, if the NHS tried to do the same in the UK it could be sued."

What is striking throughout the leaked papers is the eagerness of the British delegation to fit in with the ambitions of the Americans, knowing that especially after an acrimonious no-deal Brexit a US trade deal might be the nearest to a substantial deal on offer.

Despite the subsequent protestations of ministers after the unredacted documents were publicised, at no point in these meetings does anybody from the British delegation insist that the NHS would not be "on the table".

No stand taken

Despite the subsequent protestations of ministers after the unredacted documents were publicised, at no point in these meetings does anybody from the British delegation insist that the NHS would not be "on the table".

However it's also clear that the US delegation's interest in the NHS is almost entirely focused on drug patents (and protecting higher prices) and on free flow of data.

Boris Johnson's ministers are no doubt quite willing to "sell off" the NHS to American corporations, and the "ratchet" clauses in free trade agreements would potentially restrict options to bring privatised services back in-house.

However there is no evidence so far that there are any potential American buyers lining up to take over a deficit-ridden, under-funded and under-invested service.

Campaigners want to keep it that way: and there is no doubt – despite the denials all round – a Johnson government would be the most amenable to striking a deal with the US which would impact on the NHS with potentially disastrous consequences.

What are the main parties offering?

Election manifestos are not the place to find detailed health policies, but they do give an insight into how the parties are responding to calls for credible plans to solve the crisis in our health service. Here is a quick round-up on where the three major parties, plus the Green Party, stand on some of the central issues of concern for the NHS and social care.

Funding

The general consensus of opinion (think-tanks, BMA, IFS etc.) is that the NHS needs at least 4% per year over the next five years to maintain the current level of service, but to make any meaningful progress on its major problems, including staff shortages, mental health provisions and waiting times, the NHS will need funding growth of around 5% a year over that same period.

The Labour Party has pledged to increase expenditure across the health sector by an average 4.3% a year, the Green Party has pledged 4.5%, the Liberal Democrats have pledged 3.8%, and the Conservatives have pledged around 3.1%. The figure for the Conservatives spend has been calculated by The Health Foundation as no total health budget was published by the Conservatives.

The Green Party pledge most, but an analysis by The Health Foundation of the three main parties, concludes that only the Labour funding promise will enable improvements in care to take place, whilst the Liberal Democrats pledge will maintain current levels of care. Planned funding under the Conservatives, however, is not enough to maintain the current levels of care.

Staffing

The NHS has a staffing crisis with an estimated 100,000 vacancies. The policies of the last Conservative Government, including the axing of the nursing bursary and Brexit, have fueled this problem.

All four parties aim to reinstate the bursary in some form, although only the Labour Party promises to reinstate bursaries for nurses and other allied health professionals.

The Conservatives and the Liberal Democrats only plan to fund bursaries for nurses doing training in areas with staff shortages and in certain regions. The Green's pledge is not specific.

The Labour Party has pledged to increase expenditure across the health sector by an average 4.3% a year, the Green Party has pledged 4.5%, the Liberal Democrats have pledged 3.8%, and the Conservatives have pledged around 3.1%.

One of the key promises of the Conservative manifesto is the pledge to deliver 50,000 more nurses, although the manifesto is unclear as to the timescale for delivery. The figure of 50,000 nurses includes retaining 18,500 nurses who might otherwise have left, so the actual figure for additional nurses is 31,500. The recruitment of additional nurses will be 12,500 from overseas and 14,000 through new undergraduate students and 5,000 would be degree apprenticeships.

The viability of recruiting so many overseas nurses given the brutal immigration policies from the Johnson and May governments has been questioned, however. The Conservatives plan to increase the NHS surcharge payable by people from non-EEA countries from £400 to £625 per year and extend it after Brexit to people from EEA countries - another move that will make the UK a less attractive location for healthcare staff. Plus there is the issue of the £30,000 minimum salary for migrants and how this will be applied to healthcare staff.

In contrast, both Labour and the Liberal Democrats promise to develop ethical recruitment policies for overseas staff. In addition, the Lib Dems note that they will also maintain freedom of movement.

Recruitment and training of staff is expensive and Full Fact has raised doubts over the minimal £879 million allocated by the Conservatives to funding the extra nursing staff and reinstating the bursary for student nurses — with a minimum of £5,000 per year.

Full Fact argues that the full cost of employing 50,000 Band 5 nurses could be as high as £2.6 billion per year, far more than the almost £900 million allocated.

The Conservatives promise of 6,000 extra GPs also grabbed attention, with the related promise of 50 million more appointments each year. The promise had already been made by Matt Hancock – and exposed by *Pulse* magazine as another misleading claim, including 3,000 trainees along with 3,000 qualified GPs in the total.

Labour has a number of policies in its manifesto to target the staffing crisis. As well as the restoration of bursaries, there is also a plan to increase the number of health visitors and school nurses and expand the number of GP training places by 5,000 per year.

Labour promises NHS staff a 5% rise in pay in

2020 followed by year-on-year above inflation pay rises. The party says it will enshrine safe staffing levels into law; Wales and Sotland have already done this.

The Liberal Democrats pledges include action on the pensions crisis, GP numbers and a workforce strategy. The Health Foundation notes, however that "the manifesto acknowledges that [the workforce crisis] will require investment in recruitment, retention and making the NHS an attractive place to work. Yet the funding promised [by the Liberal Democrats] falls short of the amount needed for workforce training, despite chronic staffing shortages."

Infrastructure

The NHS's infrastructure is crumbling and disintegrating – 50% of GP surgeries are not fit for their current purpose, according to the BMA, and recent data shows that £6.5 billion is needed to complete the backlog of maintenance needed in hospitals and clinics.

Back in 2017, the Naylor report estimated that £10 billion would be needed to make the NHS fit for purpose and deliver the plans that had been drawn up around England to improve the NHS. The plan was for the NHS to raise at least £6 billion of this itself from land and property sales.

What do the main parties promise for our crumbling infrastructure? Well the Conservatives highly publicised promise of 40 new hospitals, was almost immediately exposed as a sham. We now know that the promise is just £2.7 billion for six upgrades to currently existing hospitals. The funding for the remaining '34 hospitals' only consists of £100 million to develop business proposals.

Furthermore, as the bill for backlog maintenance of NHS infrastructure is around £6.5 billion, the £2.7 billion for six projects just scrapes the surface of the problem.

Since the Naylor report in 2017 hospital trusts have been ramping up their sale of land and assets, but as the maintenance bill keeps rising, this approach appears to be having little impact on spending on infrastructure.

Labour promises to invest £15 billion in infrastructure to bring capital spending up to the international average and to halt the sale of NHS land and assets driven by the Naylor review.

The Liberal Democrats have promised to spend £10 billion and the Greens will focus funding on the construction of new community health centres, bringing health services closer to people's homes.

Social Care

Social care is in crisis with demand rising and real problems with attracting and retaining staff. Years of austerity has led to major cuts in services and serious problems in access to care. This has also had a knock-on effect on the NHS as patients well enough to leave hospital can not due to a lack of care packages.

The three main parties have all pledged more money for social care. But an analysis by The Health Foundation, found that none have pledged enough to meet the growing demand or improve pay for social care staff. The estimate is that an additional £12.8 billion is needed for social care to bring it back to levels of access seen in 2010/11.

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Out of the three main parties, only Labour has set out any concrete proposals for reform, with a headline pledge of free personal care for the over-65s. The plans also include building a 'national care service' and a life-time cap on social care costs. They will plow in an additional £11.1 billion for social care by 2023/24, according to the Health Foundation analysis.

The Liberal Democrat plans, which according to the analysis by The Health Foundation amount to £2.9 billion in additional spend by 2023/4, include establishing a cross-party convention to agree a long-term funding model for health and social care and introduce a cap on the cost of care.

The Conservative manifesto says the least of any of the parties opting just to say they plan to "build a cross-party consensus on long-term social care funding." Their additional spend is just £1.1 billion.

Several Conservative policies, including Brexit and the minimum salary level of £30,000 for migrant workers, will actively exacerbate the problems in social care. These policies will block new recruits to care work and leave nursing homes and domiciliary care companies struggling to keep services running.

Privatisation and restructuring reform

The NHS has been in a state of reorganisation for many years now - the Health and Social Care Act 2012 ushered in competition, privatisation and major changes to the way the NHS is organised.

The failings of the tendering system and the forced competition between NHS organisations have made it unpopular throughout the NHS. It has disrupted the planning of healthcare and wasted precious resources.

The Labour Party and the Green Party pledge to repeal the H&SC Act and so end competitive tendering and privatisation across the NHS. Labour promises that all integration of care will be delivered via public bodies.

In contrast, the Conservatives and Liberal Democrats only promise to make changes to the legislation in the 2012 Act that will end compulsory tendering and competition between NHS organisations. These are the changes that NHS England proposed in the January 2019 Long-Term Plan.

The years of top-down restructuring of the NHS that began with the 2012 Act will carry on, according to the

Conservative manifesto, as it pledges to continue with the restructuring set out in the Long-Term Plan.

Organisations put in place under the 2012 Act, such as the CCGs, are now being merged and integrated under plans for Integrated Care Systems (ICS). It is likely that NHS outsourcing will continue due to pressure on capacity and the structure of the proposed integrated care provider contract. These plans confirm a U turn on key elements of the Lansley reforms (H&SC Act 2012) but do not block the possibility of further NHS privatisation.

Labour too would introduce new NHS legislation, but to reinstate the duty of the health secretary to provide care to all citizens, which was removed under the Coalition's reforms in 2012.

Public Health

Under the last Conservative government, the responsibility for public health was transferred to local councils and funding was cut. By 2020/21 funding for public health will have been cut in real-terms by 25% on 2015/16 levels or around £1 billion. This has had a major impact on service levels, particularly in more deprived areas.

Labour promises to address the shortfall in funding with an increase of £1 billion in spending on public health. The Liberal Democrats also promise to make good the shortfall but without mentioning a figure. Both these parties appear to appreciate the importance of public health services to our society and people's well-being.

They both outline a number of pledges, many focused on food and drink, including minimum unit pricing for alcohol, extending the Soft Drinks Industry Levy to juice and milk-based drinks and approaches to regulate junk food advertising and sales.

The Conservative manifesto, on the other hand, does not address this issue in much detail, instead it says they will "invest in preventing diseases as well as curing them" and try to "empower people with lifestyle related conditions to live healthier lives."

Waiting times

In November this year, data from the NHS showed that key targets for cancer, hospital care and A&E have been missed for over three years. The delays for hospital care and in A&E hit their highest levels since both targets were introduced.

Less than 75% of people who went to A&Es in England in October were treated and then discharged, admitted or transferred within four hours – the smallest proportion since the target was introduced in 2004. In September 2019, 4.42 million patients were on the waiting list, the highest number ever and 76.9% of cancer patients starting treatment within 62 days - below the 85% target.

All these problems can not be addressed in isolation and are inextricably linked to funding of both the NHS and social care.

As already outlined, the Conservatives funding plan does not provide enough money and no plans have been put forward to solve the problems of social care.

So although the manifesto lists pledges for waiting time reductions, in reality there will not be sufficient funding to have any impact.

Labour plans to introduce free prescriptions and annual dental check-ups for all, and to not let NHS data be exploited by international technology and pharmaceutical corporations.

Mental health services are in crisis at present due to lack of staff and funding, with high waiting times and a lack of sufficient infrastructure and beds. Children and adolescent services are particularly badly hit.

Mental health is discussed in all four manifestos, with all four parties, Labour, Green, Liberal Democrat and Conservative, pledging to treat mental health and physical health with the same urgency, however as already discussed this will only happen if funding is sufficient.

Other pledges

All the parties have a number of other pledges relating to healthcare.

Labour plans to introduce free prescriptions and annual dental check-ups for all, and to not let NHS data be exploited by international technology and pharmaceutical corporations.

Following the considerable media coverage of possible drug price rises under any post-Brexit trade deal with the US, it is interesting that Labour plans to establish a government generic drug company, so if fair prices are rejected for patented drugs, the provisions of the Patents Act, compulsory licences and research exemptions can be used to secure access to generic versions. Labour also plans to plant an 'NHS forest' to ensure the organisation can become carbon neutral.

Both Labour and the Liberal Democrats have pledged to make PReP for HIV prevention available on the NHS.

The Conservatives announced an extension of the Cancer Drugs Fund into the 'Innovative Medicines Fund' and a doubling of investment in dementia research and speeded up trials. However, Brexit has already led to a significant 'brain drain' of academics and researchers from UK universities.

The charity Alzheimer's Research UK has already warned about the negative effect of Brexit on research into dementia, with a loss in funding - dementia research in the UK has benefitted hugely from EU funding over recent years - and the loss of researchers and collaborations with European researchers.

And finally the regular battle over car parking fees should get a mention - Labour will scrap them for all: but the Conservatives will end hospital car parking charges only for those in "the greatest need" plus staff working night shifts.

Hillingdon Hospital set to crumble for six more years

Hillingdon Hospital is the local hospital for Boris Johnson's Uxbridge constituency: but it exhibits all the signs of the crisis caused by years of under-funding.

Hillingdon is one of many trusts facing large and escalating backlog costs for maintenance, but is not one of the six trusts singled out for new or rebuilt hospitals. Instead it is one of the 21 trusts included in the 'fake forty' announcement of 'new hospitals' while only receiving a share of a minimal £100m in "seed funding" to develop a business plan.

This means Hillingdon will get no significant additional investment to address the crumbling buildings until at least 2025.

£192m repair bill

Yet the most recent Annual report emphasises the scale of the bill for repairs and new equipment – which was estimated at £191.6m in 2017 (although the official NHS tally of backlog maintenance was much smaller at £109m in 2017-18 and only slightly lower for 2018/19 at £107m), and how pressing the backlog pressures are:

The Hillingdon Trust's 2018-19 Annual Report admits that:

"The estate has suffered from underinvestment over an extended period and many building fabric and services are failing or are beyond economical repair and their design life cycle.

"A recent survey highlighted that 81% of the Hillingdon estate and 51% of the Mount Vernon estate has a condition that is 'operational but major repair or replacement will be required soon' or worse.

"… The survey also revealed the immediate need to invest significant capital over the next four years to prevent the condition of the estate deteriorating further therefore compounding the overall backlog cost.

"The Trust recognises the condition of the estate has a direct impact on the ability to provide a safe environment for patients and the importance of a clean, safe environment for all aspects of healthcare should not be underestimated.

Unfortunately the condition and age of the estate makes it difficult to meet modern standards and this has the potential to cause infection control issues if not addressed appropriately."

The Trust also has a recurrent underlying financial deficit and reported a final deficit in 2018-19 of £25.9m: but this was after receiving £24.5m of "central cash support" to prop up the budget, which is expected to continue this year, and adds to an accumulation of loans adding up to almost £60m.

The pressures on the trust have also meant a growing number of delays in elective treatment, with only 51.7% of allergy patients and 55.8% of pain management patients being treated within 18 weeks, well below the 92% target. There are also delays in Paediatric Dermatology, Rheumatology, Gastroenterology and Trauma and Orthopaedics all of which on less than 72%.

Circle buys out major UK hospital chain

John Lister

Circle Health, the company best known for its disastrous failure to run Hinchingbrooke Hospital, one of the smallest NHS general hospitals, and its unsuccessful court challenge to losing its contract to run a treatment centre in Nottingham, is buying up the largest private hospital chain in Britain, BMI Healthcare.

This will take Circle from a small scale business that had never made a profit, and was valued at £75.2m when it was taken over and delisted from the Stock Exchange in 2017 by hedge funds Toscafund and Penta Capita, to a major company with a combined annual revenue of nearly £1 billion, with 54 hospitals and over 2,600 beds.

BMI, which was previously owned by South African private health corporation Netcare, is being taken over for an undisclosed amount, as Netcare pulls out of the British private health care market after thirteen years.

Plummeting performance

Toscafund first took over a substantial share of Circle in 2015 shortly after the firm pulled out of the Hinchingbrooke contract. Financial deficits were rising and performance was plummeting as a result of the company injecting its private sector "know-how" into a previously successful hospital, alienating staff, and forcing increased reliance on more costly agency staff.

As Circle pulled out, Hinchingbrooke received the CQC's worst-ever rating for levels of care, and "inadequate" ratings for safety and leadership. The company threatened legal action against the CQC and tried to prove there had been a "Labour Party plot" to force it out of the contract, but eventually gave up.

One familiar feature of both for Circle is dependence on NHS-funded patients: Circle's own small private hospitals in Reading and Bath have always been heavily dependent on income from treating NHS-funded patients, as are BMI hospitals – where NHS work accounts for 42 per cent of revenues.

Until this year Circle's most profitable business was its NHS contract to run the Nottingham Treatment Centre, Europe's biggest treatment centre, which provides NHS-funded services including gynaecology, cardiology and respiratory medicine along with diagnostic testing and treatment for cancer.

However in May Deputy High Court judge Sir Anthony Edwards-Stuart ruled that the CCGs sending patients to Nottingham could go ahead and hand the 5-year £320m contract to Nottingham University Hospitals Trust from July. Further legal action by Circle, seeking damages from the CCGs which withdrew their contract, has not yet been dealt with by the courts.

The big question for the new expanded Circle after the takeover is completed this month is whether the new company can buck the trend of declining margins from privately insured patients and restricted NHS budgets which persuaded Netcare to pull out of the British market, and deliver increased profits.

If not, how long will Circle's proprietors, Toscafund and Penta, both noted for their focus on profitability, continue to pump in the funding to keep the business afloat?

Piecing together the puzzle on privatisation

John Lister

The election period brought a debate on the extent of NHS privatisation – with some, especially on social media, eager to over-emphasise of exaggerate the inroads that have been made by the private sector, and others trying to argue that it is a side-issue.

The first early blow in this contest was struck ahead of the election by a London School of Economics blog from David Rowland, a former head of policy for three national regulators of health professionals, now working for the independent think tank, the Centre for Health in the Public Interest (CHPI).

Entitled ***Flawed data: Why NHS spending on the independent sector may actually be much more than 7%***, the blog takes a critical look at the details provided each year in the Department of Health and Social Care's Annual Report and Accounts. This document is the source of the "settled view of the media that around 7% of NHS expenditure is spent in the independent sector."

Rowland helpfully brings together the equivalent figures going back to 2013/14, the first year after the implementation of the Health and Social Care Act which pressurised Clinical Commissioning Groups to put services out to tender and invite private bids.

But surprisingly he does not comment on the significant (almost 25%) increase in the level of NHS spending on independent sector (private) providers the year after this legislation took effect, far higher than the total increase in spending that year, of just under 10%.

Rowland's focus is on the overall percentage of total NHS spending, which appears to increase by a much smaller amount (from 6.1% to 7.3%) although this is almost a 20% increase in share of spending in a year.

Indeed he effectively ignores this increase, and argues that over the six years the share of spending has remained "remarkably stable," since the figure then rises above and falls back to 7.3% – although this, as noted the change over 6 years is a 19.7% increase, and 7.3% of £125 billion is a large sum.

Rowland's objection to the way the figures are presented by the Department are set out clearly, and some points are quite obvious: for example he highlights the £1.3 billion spent in 2018 by trusts on sending patients to private hospitals – a figure that has more than doubled since 2013/14 and clearly should be included in spending totals.

It is also fair for him to point out that almost all of the money paid to local authorities has been for them to commission nursing care and social care that is in practice delivered by the private sector. This spending was £2.8 billion in 2018-19, although the blog does not appear to go on to separate out this spending in the alternative table.

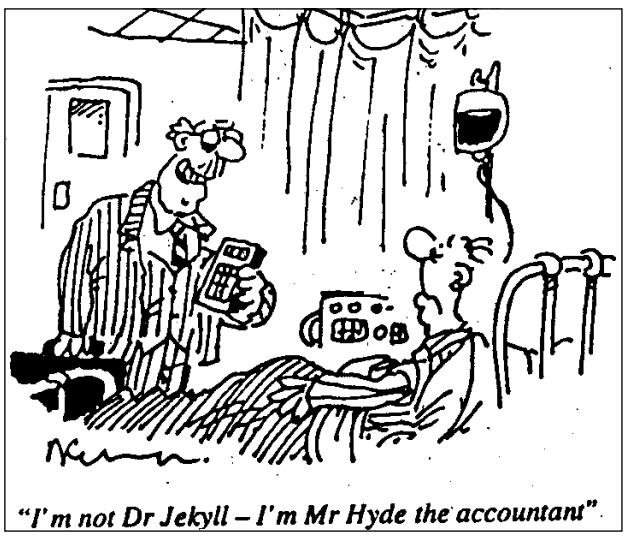
If GP and dental spending are deducted, Rowland's figures show £13.5 billion was spent on private providers in 2013-14, rising to £18.4 billion in 2018-19, a 36% increase

Rowland also argues that many voluntary sector organisations and not for profit companies are to all intents and purposes private sector providers, although again the implications of this are not worked through in the final figures.

We can also agree that a very large share of pharmacy and ophthalmic services have been effectively privatised, with Boots, Lloyds Pharmacy, Specsavers and Vision Express cashing in on NHS contracts.

But much more controversial is Rowland's argument that General Practice and General Dental services should be similarly bracketed as independent sector (i.e. private sector) spending – effectively regarding all GPs and all NHS dentists as the equivalent of Virgin Care or The Practice, and ignoring NHS dentistry. The case for this is not clear, and while campaigners will continue to fight to remove for profit companies from GP services the extent to which the relatively small corporate sector in GP services can be singled out from the total budget is not clear.

Before moving on to present his alternative breakdown of spending Rowland also quite reasonably



"I'm not Dr Jekyll – I'm Mr Hyde the accountant"

questions the sense of comparing private spending with the total of Department of Health Spending, rather than NHS England's actual spending on health services.

This does have the effect of appearing to minimise the level of private spending. Obviously if this was to be changed, the comparison would need to be changed for each year to ensure consistency, so it would make a one-off difference, but then the benchmark would remain the same.

Having made these points Rowland notes:

"On this basis, we find that in 2018/19 £29 billion was spent by NHS England on the independent sector, which is around 26% of total expenditure. This percentage of the NHS's expenditure on the independent sector has stayed fairly constant for the past six years."

With a nod to those of us who object to including all GPs in the private sector, he adds:

"If General Practitioners are excluded from this calculation, the figure is £21 billion, or around 18% of total expenditure on the independent sector."

In fact the inclusion of the large sums spent on GP services and the smaller, but significant sum spent on General Dental services skews all of the sums, and diverts from the significant growth in the share of NHS spending on private providers.

Indeed if GP and dental spending are deducted, Rowland's figures show £13.5 billion was spent on private providers in 2013-14, rising to £18.4 billion in 2018-19, a 36% increase, and rising from 14% of NHS England spending in 2013-14 to 16% (almost £1 of every £6 spent) by 2018-19.

This is useful information for campaigners. It's a shame it is so complex a process to get to it that few will make use of it.

Concentrations of privatisation

However modest the overall percentage of spend on private providers might be, we know that within certain services the concentration of private provision is much higher than the average.

This imbalance is highlighted by a new report researched by the Nuffield Trust for the Institute of Fiscal Studies. Recent trends in independent sector provision of NHS-funded elective hospital care in England does exactly what it says on the cover: but it begins with the Department of Health figures we have just seen criticised.

The motivation for the IFS commissioning specific NHS research appears to be this "neutral" body's wish to question Labour's election manifesto and commitments:

"Labour has vowed to 'end and reverse privatisation in the NHS in the next parliament', signalling an ambition to end – or at least significantly reduce – the role played by private providers in treating NHS-funded patients."

Its key findings show that while emergency care remains almost exclusively provided by NHS hospitals, there has been a significant privatisation of the provision of NHS-funded elective care, from "almost none" in 2003-4:

"ISPs [independent sector providers] account for a small, but growing, share of NHS inpatient activity. They provided 609,549 NHS-funded elective episodes in 2017–18 (6% of all NHS elective activity) ….

"Wider NHS activity has increased substantially over the last 15 years, with ISPs accounting for one-sixth of this growth.

"The NHS is becoming increasingly reliant upon ISPs for some types of elective work. For example, in 2017–18, ISPs conducted 30% of all NHS-funded hip replacements, 27% of inguinal hernia repairs and 20% of cataract procedures. Replacing this capacity within NHS providers would therefore require careful planning.

"In some cases, ISPs have provided additional capacity for the NHS, while in others they appear to have been used as an alternative provider of care. 82% of the growth in hip replacements between 2003–04 and 2018–19 was accounted for by ISPs."

"The NHS is becoming increasingly reliant upon ISPs for some types of elective work. In 2017–18, ISPs conducted 30% of all NHS-funded hip re-placements, 27% of inguinal hernia repairs and 20% of cataract procedures.

The researchers argue that the private sector is important, but a relatively minor player in the provision of NHS elective care: "It is important to note that while volumes have increased at ISPs, this increase still only represents a small part of the growth in NHS activity over this period."

Between 2003–04 and 2017–18 NHS-funded elective episodes at NHS hospitals increased by 3.2 million, an increase of 48.8%, while total NHS-funded elective episodes increased by 3.8 million, so one-sixth (16.1%) of the extra operations were by private providers.

But in some specialties the private sector played a bigger role: "by 2017–18, ISPs accounted for 19.6% of all NHS-funded cataract surgeries, 27.3% of inguinal hernia primary repairs and 30.3% of hip replacements."

On hip operations the private sector had the lion's share of the increased caseload, with NHS hospitals increasing by 5,101 compared with 23,354 additional procedures (82.0% of the total increase) by ISPs.

The study offers no explanations or discussion. The extent to which this was due to New Labour's policy of subsidising "independent sector treatment centres," with contracts for which only the private sector could bid, is not discussed, but the graph shows most of the

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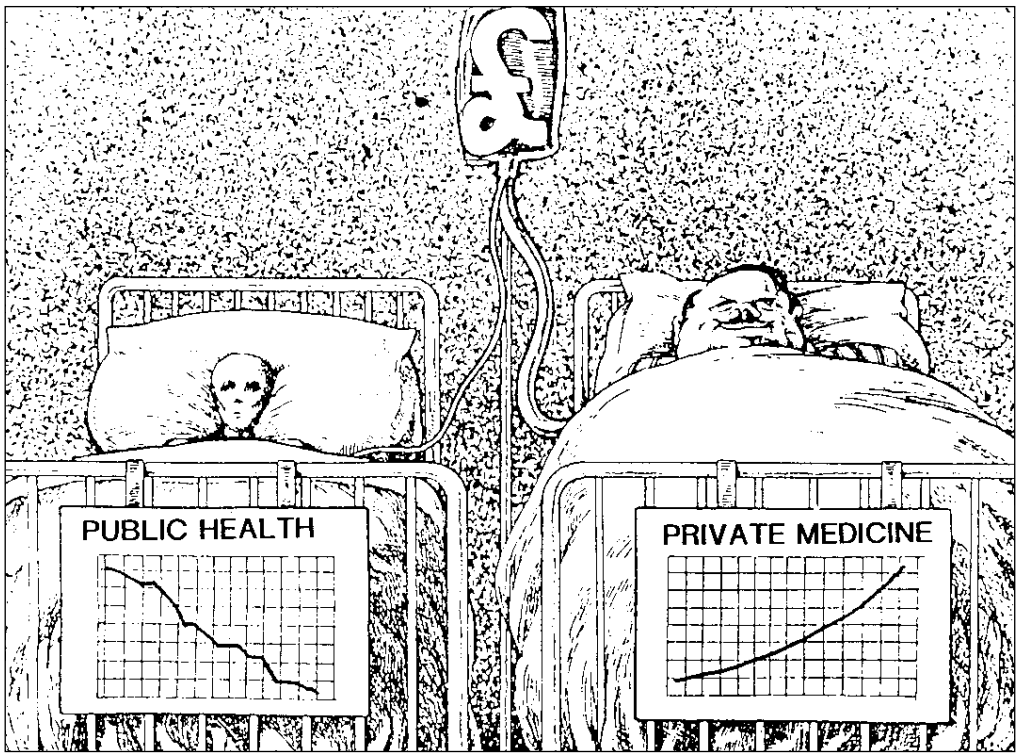
increase in private sector share of hip replacements had taken place by 2010.

The researchers point out that the pattern is "even starker" in the case of hernia repairs, where private sector caseload grew by 13,478 over the period, and NHS hospital volumes actually fell.

The paper concludes by noting the geographical variation in the level of private provision of elective treatment, with 40% of hip replacements being done by private providers in the South East and East Midlands, compared to just 11% in London.

But it offers little discussion on the reasons for the shift of activity to private providers, or the geographical differences: one possible factor is the high levels of NHS bed occupancy linked with increased pressure on emergency services, along with potential financial consequences of failing to deliver performance targets for elective care.

It appears that the IFS would be happy for us to conclude that while privatisation is a significant factor in these specialist elective services, the scale of the private sector role is great enough to mean there is 'no alternative' to continued substantial reliance on private hospitals to deliver NHS-funded treatment.



Corbyn claim justified: Nuff said?

The third approach, taking another distinct view is a short report from the Nuffield Trust entitled Privatisation in the English NHS: fact or fiction?

Written by Nuffield Trust policy wonks Helen Buckingham and Mark Dayan it makes no reference to David Rowland's blog, or to the Department figures, but annoyingly asserts a different figure:

"Around 22% of the English health spending goes to organisations that are not NHS trusts or other statutory bodies."

This figure is not explained, referenced, or linked in with the published statistics. The authors go on to state that:

"this includes many services that the general public would regard as being within the health service. For example, almost all the GPs, dentists, pharmacists and opticians who treat NHS patients are private businesses, and have been since the inception of the NHS in 1948."

They then go on to discuss private (Virgin) and non-profit providers delivering community health services, private and voluntary sector providers of 'talking therapies' and the right of patients seeking elective treatment to choose from a list of providers including private hospitals.

They do however concede that "Much of the inpatient provision for people with a learning disability or mental health problems and high levels of need is privately run."

They go on to discuss the extent to which privatisation has grown in recent years, and argue that:

"Adding together all non-NHS providers, looked at as a proportion of spend to adjust for the generally increasing budget, the purchase of private health care has been both significant and relatively stable, at between 20 and 22% for the last nine years.

"Regardless of whether we include charities or not, private spending is actually proportionately lower in 2018/19 than it was in 2015/16."

However the authors accept that Jeremy Corbyn's claim that 'privatisation has doubled since 2010' is focused "primarily on areas such as hospital and mental health care, rather than 'primary care' areas like GPs and opticians," the authors admit – perhaps surprisingly for some readers – that:

"his claim that it has doubled is correct in cash terms, although the context is that health spending overall has risen by a third. But even in terms of proportion, we do see a notable expansion in private spending in these areas."

They note that, private spending has effectively "flatlined for the last three years:"

"This may reflect that while the 2010 to 2015 coalition government had several initiatives to increase competition and private provision, there have been no more major moves in this direction since."

They note the debate in which some campaigners have argued that moves towards "integrated care systems" (ICSs) will inevitably increase the role of private providers, but also note the comment of David Hare, the chief executive of the main lobby group for private providers working with the NHS, who has said that he does not expect his members to take on ICS contracts.

The Nuffield paper pulls up short of the "nothing to see here, move along" school of thought promoted by the Health Service Journal.

Like Rowland's blog and the IFS study it can help us build a picture of what is happening, although it is not sufficient to do that in itself.

It's up to campaigners and trade unionists to identify an approach that is credible and focused on the main issues – and one that recognises how much of the NHS remains a public service, under public ownership, and how hard we need to fight to defend it.

"Adding together all non-NHS providers, looked at as a proportion of spend to adjust for the generally increasing budget, the purchase of private health care has been both significant and relatively stable, at between 20 and 22% for the last nine years.

Private sector in the NHS market: **A catalogue of failures (2013-19)**

The history of outsourcing in the NHS is marked by a catalogue of significant failures. The set up and performance of these contracts is opaque. The private providers are not subject to the same scrutiny as the NHS and yet profit-led companies are entrusted with the care of millions of NHS patients.

At this election all the parties are queuing up to remove all, or parts of the handiwork of the coalition government, who instituted a seismic experiment in NHS outsourcing and competitive tendering in 2013.

Since then over £25bn NHS clinical contracts have been advertised and around 40% of that value has been awarded to the private sector.

Following this policy is now a long trail of contract failures across a wide range of NHS services. We list dozens of examples below, to show the scale of the outsourcing under this policy and to contribute towards a national appraisal of the impact that has been dodged by government.

Private firms providing care to NHS patients are conflicted, between on one-side, the need to keep down costs and generate a financial return, and on the other, the demands from the NHS to provide the best care they can and to maintain a constant service.

Repeated failures show that these motivations cannot be reliably reconciled. Profit-led companies have been tempted into compromising care on many occasions, to the detriment of patients. Companies have walked away from numerous NHS contracts when profits decline, leaving the NHS to pick up the pieces.

The risk to patients and services of outsourcing care is higher the more it is used. However, a Boris Johnson government is very likely to continue with it, even if the current tendering rules are changed.

In fact, the pressure on the NHS and the decades of cuts in bed capacity mean that all parties would have to stomach continued outsourcing in the short term as in some areas the NHS is heavily reliant upon it. Over 30% of mental health inpatient care is provided by the private sector and 70% of adult social care staff work in the independent sector.

Of course, some dispute whether outsourcing is privatisation at all, often because there is no Thatcher-style share sell off, but academic definitions are clear and include outsourcing alongside many other tactics employed by governments in a patchwork of privatisation strategies.

It is a long road back to a publicly provided NHS. It would need both steps to hardwire public provision right across health and social care and a huge investment in raising NHS capacity.

And if we don't take these steps? Then either through cock-up, circumstance or design the steady privatisation of our NHS will continue.

Community Services

The term 'community services' covers a wide range of services provided in the community, including many services that would previously have been provided in a local hospital.

In July 2019, the private maternity service One to One Midwives gave pregnant women just a couple of days notice that it was withdrawing the services it provides to the NHS. The company entered insolvency proceedings soon after. This left about 1,700 pregnant women, some due to give birth within weeks, having to find new midwives. The company, which provided midwifery services to women in Essex and the north-west of England, said the contracts did not pay enough to make the service financially sustainable.

This was the second midwifery company to collapse – Neighbourhood Midwives, which provided midwifery services to women in the south-east, closed in January 2019.

In May 2019, Concordia Specialist Care Services terminated a contract to provide community dermatology services in Essex two months early with just five days notice. The original contract was for five years, but the CCG announced in October it was being cut to two years and ending in July 2019. The cut in contract time followed a CCG inspection of the services the company provided in Fryatt Hospital, Dovercourt. The inspection found "standards of hygiene and cleanliness in a number of areas did not comply with national standards, medication was out of date, specimens were inappropriately stored in a medication fridge and Concordia staff were unaware of how to access organisational policies".

Virgin Care won a seven-year £280 million contract in March 2015 to provide services for the frail and elderly in East Staffordshire. Under this fixed-price contract, Virgin Care was to be the prime provider and could sub-contract the work to other organisations. The contract was dogged by contractual and financial issues.

In October 2017, Health Services Journal (HSJ) reported that Virgin Care was demanding £5 million more from the CCGs. As this was not provided by the CCGs, Virgin Care terminated parts of the contract. Then in April 2019, Virgin announced that it is to leave the contract entirely in April 2020, three years early. The reason given is that Virgin and the CCG were unable to come to a new financial agreement. Virgin stated that it is not able to run the service on the money provided by the CCG and it is not prepared to make up the shortfall.

The quality of service provided by Serco was investigated in Suffolk, where it was awarded a £140 million contract in October 2012 to run community services.

The company was criticized for failing to meet key response times. In January 2014, a report from Serco to the council's health

Continued overleaf

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scrutiny committee showed that Serco was not hitting three of its key performance indicators in community health response times.

For example, it failed to meet urgent four-hour response targets - for nurses and therapists to reach patients at home 95% of the time (only achieving 89.3% in November 2013). Before Serco took over, the target was achieved 97% of the time. In September 2015, Serco relinquished the contract and an NHS consortium including Ipswich and West Suffolk Hospital Trusts took over the running of community services.

In 2014 Healthcare at Home was bombarded with complaints over its home delivery of essential prescriptions to NHS patients. The largest issue was its failure to deliver all medications - some life-saving - on time. Problems emerged after Healthcare at Home switched from using an in-house delivery service to Movianto: an American logistics firm operating throughout Europe. When Movianto's IT systems failed many patients were left without deliveries.

Mental Health Services

The NHS has a large number of contracts with private providers for mental health services, both residential and in the community. The last few years have seen a succession of highly critical reports by the Care Quality Commission (CQC) on residential mental health services with many rated "inadequate" and others closed completely or to new patients.

In September 2019 the CQC published a report on residential mental health, noting that it had found 28 mental health units run by private companies to be "inadequate" in the past three years. The Royal College of Psychiatrists is so concerned about the poor standards of care that it has written to the secretary of state urging him to commission a public inquiry led by a high court judge.

The CQC has rated 16 independently run mental health units as inadequate so far in 2019 and it rated four others in the same category in 2018, and eight in 2017.

In November 2017, a CQC report found that nearly three-quarters of private clinics were failing to hit regulatory standards of care. The report was based on inspections of 68 independent services providing residential detoxification services over the last two years.

Hospitals run by the Huntercombe Group have received particularly critical reports after inspections by the CQC. In December 2018, an inspection by the CQC of the company's hospital for children and adolescents in Norwich found serious concerns. The CQC took immediate action to protect those using the service, including enforcement action to remove the registration for the hospital. The Huntercombe Group then closed the service and the patients had to be found places elsewhere.

Earlier issues with the company's hospitals, include in September 2017, Watcombe Hall, being closed indefinitely after the local NHS hospital raised concerns about the number of young patients being admitted from the unit suffering from malnutrition and dehydration and in 2016, the company's hospital in Stafford was placed in special measures and told to urgently improve in 24 areas.

Cygnet, a specialist mental health provider that operates more than 150 facilities across the UK, which between them have more than 1,000 beds, has been repeatedly criticised by the CQC. From January to September 2019, mental health units run by the company have been found to be inadequate by the CQC six times.

In November 2019, the CQC ordered that the Cygnus Acer Clinic in Derbyshire must stop admitting new patients due to serious concerns over patient safety, including a huge shortage of trained staff. In 2019 there were two serious incidents, one of which resulted in a patient taking their own life by hanging.

In September 2019 the CQC published a report on residential mental health, noting that it had found 28 mental health units run by private companies to be "inadequate" in the past three years.

In October 2019 an inspection report on Cygnet's Newbus Grange hospital in Darlington, noted how the CQC had found a patient with "unexplained injuries", and there were opportunities for patients to kill themselves and staff asleep while on duty. The unit was put into special measures and its 10 patients moved elsewhere.

In July 2019, the CQC downgraded the hospital at Godden Green to "requires improvement". In June 2019, HSJ reported that multi-agency investigation had been launched into Cygnet's 65-bed hospital in Maidstone, whose 15-bed male psychiatric unit had had a "disproportionate" number of safeguarding alerts for patient-on-patient attacks.

The Priory, one of the country's leading provider of mental health services owned by the US company Acadia, has been the subject of several reports of failures in care in recent years, including patient deaths.

In July 2019, the CQC placed two of the company's hospitals in special measures – Priory Hospital Blandford in Dorset and Kneesworth House in Royston, Hertfordshire. The hospitals were found by the CQC to be unsafe and uncaring and rated them both as inadequate. The hospitals have been given up to six months to show improvement or face closure.

Earlier in the year in February, the Priory's hospital for children with learning disabilities in High Wycombe was closed, following a CQC report that gave the unit an overall rating of 'inadequate'. The hospital had only opened in April 2018 and catered for children aged 13 to 17 with learning disabilities and/or autism.

In 2018, two of the company's hospitals - Southgate, North London, and Roehampton – were rated "requires improvement" overall by the CQC.

In 2016, an inquest ruled that the death of a 14 year old Amy El-Keria at a Priory hospital in 2012 was as a result of months of serious failings at the hospital, including staff failing to pass on the fact that she had spoken of wanting to end her life.

Also in 2016, the family of 17-year-old Sara Green, who died in the Priory Royal in Cheadle in 2014, called for the company to have its NHS contract cancelled. In March 2016, the Priory and Solent NHS Trust admitted liability for the death of 15-year-old George Werb, who had been a patient at the Priory Hospital Southampton.

In June 2019, St Andrew's Healthcare's hospital in Northampton was rated "inadequate" by the CQC. The watchdog had found that adolescents were kept in unsafe seclusion rooms for excessive amounts of time and without beds, blankets or pillows. It was reported that some patients had been in seclusion for years and earlier in 2019 the BBC's Victoria Derbyshire programme was given footage of a teenager reaching their arm through a door hatch to enable contact with their parents during a visit to the hospital.

Surgery/ Diagnostics

A private hospital run by BMI Healthcare that treats up to 10,000 NHS patients a year, put their safety at risk according to a report by the health watchdog. The Care Quality Commission (CQC) rated Fawkham Manor hospital in Kent as "inadequate" - the worst possible ranking. Staff told the CQC that financial targets were prioritised over patient safety at the hospital, where NHS patients make up almost half the caseload.

In Somerset, dozens of people were left with impaired vision, pain and discomfort after undergoing operations provided by the private healthcare company Vanguard Healthcare under contract with Musgrove Park Hospital, Taunton. The hospital's contract with Vanguard Healthcare was terminated four days after 30 patients, most elderly and some frail, reported complications, including blurred vision, pain and swelling.

In a very similar set up in Devon, 19 NHS patients had the outcome of their cataract surgery reviewed after at least two had problems with their eyes following operations at a private hospital. The problems emerged on the first day of operations conducted under a contract to perform cataract operations between the NHS's South Devon Healthcare Foundation trust, which runs Torbay hospital, and Mount Stuart hospital, owned by Ramsay Healthcare.

Circle was the private provider involved in the privatisation of Nottingham's dermatology service, which in June 2015, was described by an independent report as "an unmitigated disaster". Once part of a national centre for excellence at Queen's Medical Centre, it is now much reduced, with some patients sent to a centre in Leicester. When Circle won the contract, several consultants refused to transfer from NHS contracts, leaving the dermatology service with few consultants and Circle had to employ locums.

In June 2013, the NHS temporarily stopped referrals to BMI Healthcare's Mount Alvernia hospital, in Surrey, following a Care Quality Commission report which found serious failings on patient consent, care, cleanliness, staffing levels and service quality monitoring. The report noted some staff had told inspectors breaches had been caused by initiatives designed to "save money" or for "logistical and financial reasons"

The Care Quality Commission (CQC) rated Fawkham Manor hospital in Kent as "inadequate" - the worst possible ranking.

Emergency care and ambulance services

One of the most controversial failures in recent times has been the Coperforma contract in Sussex for non-emergency patient transport. This four-year contract worth £63.5 million was awarded in 2015 by seven CCGs. Coperforma replaced the NHS's South-East Coast ambulance service (SECamb) on 1 April 2016; it was then just a matter of days, before problems with the contract hit the headlines.

By mid-April local and national press were reporting on a service in chaos, with crews not turning up to pick up patients leading to missed appointments and patients languishing for hours in hospitals awaiting transport home. Patients included those with kidney failure with appointments for dialysis and cancer patients attending chemotherapy sessions. The GMB union representing the ambulance crews said it was an "absolute shambles". Finally, in October 2016, Coperforma were forced to give up the contract.

In September 2017, the private ambulance company, Private Ambulance Service contracted to run non-emergency patient transport from hospitals in Bedfordshire and Hertfordshire went into administration. The business, which ran 126 vehicles and employed 300 people, took over the contract in April 2017.

In September this year SSG UK Specialist Ambulance Support Ltd, the largest firm providing 999 emergency and non-emergency transportation for the NHS, was put into administration.

The company provided services for ambulance trusts all across the country including South central, East of England, North East and London.

■ More examples on other parts of the NHS can be found at *https://www.nhsforsale.info/*

Australia's private health insurance system stuck in "death spiral"

John Lister

A mounting crisis in Australia's heavily subsidised private health insurance industry has even caught the attention of the Daily Mail. The situation offers a grim warning to any Tories with aspirations to undermine the NHS.

Australia currently spends the equivalent of £96 billion per year on health, to cover a population of just 25.2 million. Its universal tax-funded health care system, Medicare, was introduced in 1984, and lasted until 1996, resulting in a sharp decline in private health insurance from 70% of the population in the 1950s to just 30% in 1998.

As the European Health Management Association pointed out "In essence the Medicare system was proving too good for the private sector, so the government subsidised the private sector to allow it to compete better with the public sector."

Government-funded

Right wing Liberal governments tried to turn the tide, and brought in a 30% government-funded rebate for people taking out health insurance, initially costing $600m a year, and from 1997 imposed a penalty tax on high earners who failed to take private insurance.

From 2000 this penalty was coupled with a surcharge of 2% on private insurance policies for every year above 30 a new higher-paid subscriber was aged when they took out a policy.

Since then the private sector has expanded, along with the public sector subsidy, despite the increased cost of private provision: one analyst argued that $2.5 billion spent on subsidising private insurance in 2004-5 could "open and operate an extra sixteen 500-bed hospitals."

The latest calculations show that the public subsidy to private health care has mushroomed to $9 billion a year, with government-funded rebates increased ten-fold to $6bn, plus another $3bn on private medical services for patients. 60% of all surgical procedures are performed in private hospitals.

Less healthy pool

However premiums are arising faster than wages or inflation. And as a result people are dropping out of health insurance cover, especially younger and healthier people, leaving an increasingly older and less healthy pool of subscribers, which increases costs and pushes premium payments even higher.

Analyst Stephen Duckett of the Grattan Institute argues private health insurance is facing a "death spiral" and "politicians need to rethink whether or to what extent taxpayers should continue to subsidise the industry."

Duckett raised the sharp question back in February "Is it time to ditch the private health insurance rebate?" He pointed out to the comparison with failing industries:

"Over recent decades we have learnt that propping up industries in the face of consumers turning away from their products is not a long-term proposition. Private health insurance is no car industry, but it's not a sunrise industry either. Yet it receives a greater subsidy than manufacturing at its subsidised peak at the end of the 1960s."

He now says "future reforms to PHI should be made based on a clear view of the desired role of private health care given that it functions alongside a universal publicly funded scheme, Medicare. To what extent is private hospital care a substitute for public hospital care? To what extent is it a complement to the public system?

"If the purpose of private health care is to complement the public system – providing services, facilities and amenity beyond those considered necessary for public funding – then the argument for public subsidy is weak."

The Grattan Institute is not against private medicine, but has blamed "greedy" private sector doctors for "excessive" private hospital costs and "egregious" bills for specialist care, with some patients facing bills at more than twice the official Medicare Benefit Schedule fee.

The latest calculations show that the public subsidy to private health care has mushroomed to $9 billion a year, with government-funded rebates increased ten-fold to $6bn, plus another $3bn on private medical services

Saving private healthcare

It notes private patients stay in hospital 9 per cent longer than public patients with similar conditions, and has put forward recommendations identifying $2bn in possible savings a year, declaring if the changes are realised, it could "save private health care in Australia".

Earlier this year more searching questions were asked on the value of private health insurance for older Australians after a 78-year old woman who was privately insured was told by private hospital in Hobart she was "too old" to be admitted and that it was "outside of [hospital] protocol" to treat her.

More than half of over 65s in Australia have private insurance. But ABC reports Erin Turner, the CEO of independent consumer advocacy group CHOICE Australia, who argues that in many cases, the public health system would be better equipped to suit patients' needs.

"It's particularly good in emergency scenarios and you have access to great quality doctors and trained professionals," she said.

In April the health minister brought in a restructuring of health insurance policies into different levels – bronze silver and gold, with discounts for young subscribers: but this still complex and expensive system, with its high additional out of pocket costs has not been able to stop the drift out of health insurance among younger people.

The Guardian now reports that the Australian Healthcare and Hospitals Association is now calling for a Productivity Commission review of the healthcare system asking the question of whether the private insurance system should be saved.

Lost in translation: Trust spouts jargon but misses the message

John Lister

Shrewsbury and Telford Hospitals Trust is facing a major inquiry into what is already Britain's biggest-ever scandal over maternity services, investigating the deaths of as many as 800 babies. Huge questions are being asked over its management culture, staffing levels and the safety of patient care in its A&E, most recently a CQC waraning letter over inappropriate treatment of mental health patients.

The Trust has also recently received Matt Hancock's rubber stamp of approval to press ahead with a controversial £312m plan to downgrade emergency services in Telford's Princess Royal Hospital and 'centralise' acute services on the Royal Shrewsbury Hospital 16 miles away.

So we might expect Shrewsbury and Telford Hospitals Trust to be dusting down its long-standing, controversial "Future Fit" plan, drawing up Strategic Outline and Outline Business Cases, beefing up its clinical strategy (since arguments for the concentration of services at Shrewsbury are heavily based on staffing) – and almost obsessively focused on patient safety and practical issues.

But the Trust's November Trust Board papers show us things are very different.

Future Fit appears to have been discarded within two months of being approved, and replaced by the mumbo-jumbo of a 'Hospital Transformation Programme'.

Senior managers are spouting half-understood Japanese jargon arising from its links with the Virginia Mason Medical Centre in Seattle, whose website proudly proclaims that its management mixes "basic tenets of the Toyota Production System with elements from the philosophies of kaizen and lean."

So now baffled staff in Shrewsbury and Telford have to deal with a 'Kaizen Promotion Office,' and a battery of obscurely written documents that insofar as they tell us anything make clear that there are a lot of "Gaps" – not least in understanding the kaizen approach which they think they have adopted.

According to the Transformation Programme, for example, despite six years of discussion on reorganising hospital services, which was endlessly claimed to be based on clinical criteria, **"The Trust currently doesn't have a clinical strategy".**

A Trust Board document from 'Director of Transformation and Strategy' Bev Tabernacle-Pennington also warns of a problem with the Trust's wider "strategy and vision" – admitting that even leaders attending a workshop "were not clear on these, and could not articulate the main drivers for our strategy work."

There is also concern over **"the overlap and lack of understanding about the many work streams and how these currently work to address the Quality deficits identified to date."**

If even the leaders don't understand what the Trust is trying to do, imagine how bemused other staff must be at what's going on.

They may not be impressed or enlightened by news that "The improvement methodology has been utilised to test the sustainability of the plans put in place by the ISG's for example the use of Genba walks."

Our management team have become really keen on those Japanese management techniques

Despite six years of discussion on reorganising hospital services, "The Trust currently doesn't have a clinical strategy"

But worse, the document admits that work on "Human Factor" – the most important part of kaizen and lean, the focus on empowering staff at all levels to intervene to eliminate or address human error and maximise quality and safety – is not included in the Trust's strategy. If this is true then all the efforts are being wasted.

Worse still there are no plans for engagement with staff on Human Factor to explain it and make it real, or roll out any proposals, and – in a Trust embroiled in a safety scandal – no focus on patient safety.

There is also a lack of "workforce modelling", and doubts whether the 'Out Of Hospital Programme' would be adequate to carry through the downgrading of services at Telford and relocation in Shrewsbury.

To put the tin lid on it, the Director of Transformation and Strategy admits that even the financial modelling on the plan they have been arguing for since 2013 is "yet to be completed:"

Campaigners already knew there was management talk of a "gap" of upwards of £100m between the allocated funding of £312m and the likely actual cost of the hospital upgrade.

The 'Hospital Transformation Programme' team understandably try to look on the bright side, and assure us that even though they don't really know what they are doing, they do have "a number of enthusiastic individuals" … and propose to set up still more confusing meetings, including a "Transforming Care Partnership Board."

And there are also plans to pay city accountants Deloitte for six weeks consultancy to help "form plans" and "advise" all the managers and staff who can't make head or tail out of the Japanese jargon and the directionless Trust Board.

People expecting a new hospital to be built, or services to be improved are advised not to hold their breath waiting.

THE lowdown

Health news, analysis and campaigns.
NUMBER 16, January 17 2020

Informing, alerting and empowering NHS staff and campaigners

Dash in to take charge in NW London

You couldn't make it up. Nine months ago North West London's NHS bosses were told by Matt Hancock that their long-running, ruinously expensive and impractical plan for reconfiguration ("Shaping a Healthier Future") was being scrapped.

The project had squandered almost £80m on management consultancy over the previous ten years, but never even completed a business case. One of the contractors was McKinsey.

Now NHS England/ Improvement have announced NW London's "integrated care system" should be chaired by a senior partner of McKinsey – Penny Dash.

McKinsey's website notes that she is "a leader for our work with healthcare payors in Europe, the Middle East and Africa": another McKinsey biog extends her reach to Australia. She was previously the head of strategy for the National Health Service (NHS) in the United Kingdom, and was the vice chair of The King's Fund from 2006 to 2015.

It seems that after lamentably failing to deliver a workable plan, McKinsey now gets another go.

The results so far are poor: December A&E figures include only 2 of the 4 trusts covering NW London: London NW Hospitals could only see **60.8%** of the most serious Type 1 A&R cases within 4 hours, while Hillingdon did even worse, at **56.3%**.

If this is the outcome of ten years of McKinsey's efforts, how much more "improvement" can local services survive?

UNISON has suspended strikes in Northern Ireland to ballot members on a new deal - p8-9

New buildings can mean fewer beds

The Johnson government has swept to power on the back of extensive promises to invest in and improve the NHS – but many of these promises will soon be under the spotlight.

The latest performance figures show the NHS is struggling to cope with winter demand for emergency admissions and to maintain elective services with 95% of beds occupied even after opening 4,500 "escalation beds".

But more and more people in various areas are realising that the promise of extra money for new buildings or even a new hospital does not necessarily mean more beds: it could mean fewer.

In **Poole, Dorset**, Matt Hancock has just rubber-stamped the downgrade of their local hospital, to centralise emergency care in Bournemouth, which has not met A&E targets for almost five years.

The NHS has 95% of beds occupied is struggling to cope with demand even after opening 4,500 "escalation beds".

The reconfiguration project has been allocated £147m to cover a new emergency department and critical care unit in Bournemouth – but no significant extra beds: so will the new set-up cope with demand?

In **South West London**, it has been announced that a new specialist emergency care hospital to replace Epsom and St Helier hospitals will be in Sutton: but it's also clear that the £500m project will have only 400 beds – whereas the current Epsom & St Helier Trust has 747 general and acute beds. Both of the existing hospitals would be downgraded to urgent care only: how would services cope with this reduction?

In **Shropshire**, too, a controversial £312m project signed off by Matt Hancock only months ago to rebuild Shrewsbury Hospital and "centralise" emergency services, downgrading Telford,has soared in cost to £498m, but includes no extra beds. With Shropshire's A&E already registering the worst 12-hour trolley-waits in England, and A&E demand **up 27% in a year,** how can they cope if they downgrade Telford?

Extra money does not ensure sound policies: expect more risks to be taken as ministers show their real intentions for the NHS.

IN THIS FIRST ISSUE OF 2020

Social care adds to winter pressure: what's being done?

Molly Dawson and Paul Evans

Another winter, another set of broken records for the NHS. A&E waiting times for December hit their worst level on record, with 2,000 patients waiting 12 hours for a bed. Experts cite the struggle to find social care support as one of the key causes of increased pressure.

Demand for social care is rising, but cuts in services mean that fewer people receive care.

Tens of thousands of older and disabled people are being denied basic support such as help with washing and dressing and overall Age UK estimates suggest there are 1.4 million elderly people not receiving the care they need.

The impact is familiar: neglected health conditions worsen, eventually piling on the pressure to A&E and an inpatient hospital beds.

The lack of social care packages also means many patients are stuck in hospital waiting for support to allow them to go home.

After a period of funding cuts, the government is putting some more money into social care, but like the health service, social care is also facing a workforce crisis.

Staffing shortages in the social care sector stand at 122,000. To meet the needs of the ageing population, there is a projected need of 580,000 additional social care workers by 2035.

Boris Johnson pledged to fix the social care crisis in his first speech as Prime Minister.

The Conservative manifesto said it would put £5billion towards social care over the next five years – but so far no plan has emerged.

How is social care funded currently?

The funding of social care is complex and confusing, with many people unaware of the potential costs involved until they reach a point of needing the services, but in reality it rarely ends up being free.

Even if you have care needs resulting from healthcare conditions like dementia or Parkinsons disease, you will only receive NHS funding for significant and ongoing problems.

People with dementia typically spend £100,000 on the care they need, according to the Alzheimer's Society.

Otherwise you will be directed towards your local council who are responsible for organising social care services. People with assets over £23,350 must pay for their own social care.

Even for those who get help, cuts to council funding since 2010/11, have meant that less care is available. Indeed despite recent funding increases, spending is still around £1 billion less than it was at the start of the decade.

As a result, the number of elderly people receiving publicly funded care fell by 400,000 between 2009 and 2016.

The Health Foundation estimates that an additional £12.8 billion of funding would be needed to bring back social care to the access levels of 2010/11

What has been suggested to solve the social care crisis?

Various commissions and reports have been dedicated to solving the deep-rooted issues in social care over the last 20 years. Governments of all colours have kicked the issue into the long grass, fearful of confronting voters with extra taxes or insurance payments.

The Royal Commission on Long-Term Care in 1999 called for care costs to be split between living costs, housing costs and personal care. They suggested that personal care – help with washing, feeding and medication be free at the point of use.

This was rejected by the then New Labour government, but was adopted in Scotland.

The Dilnot Commission in 2011 set out plans to protect people from extreme care costs, which the King's Fund described as a 'costed and credible' way forward. It recommended a cap on care costs after which the state would pick up the bill.

The Barker Commission in 2014 went further by calling to establish more equitable support by removing the barrier between health and social care, introducing a single ring-fenced budget and raising the amount of free social care.

Election debate

In the midst of many promises at the latest election, the Labour Party proposed plans for a 'national care service' with free personal care for over-65s.

However, the pledge had little detail to it, and the £11.1 billion funding pledge still falls short.

In fact, a Health Foundation analysis found that none of the main party's election promises pledged enough to meet growing demands. It estimates that an additional £12.8 billion of funding would be needed to bring back social care to the access levels of 2010/11.

Amongst the plans from charities and campaigners is a report by the National Pensioner's Convention - Sustainable Funding for Social Care, which describes in more detail how a National Care Service might work.

Their plan is costed at £12 billion and would provide free domiciliary and residential care to service users who are currently self-funding. It would also expand to cover:

- 1.2 million older people whose needs are currently excluded from the system,
- modernisation of residential homes,
- improved terms and conditions for care staff,

- and improved monitoring and regulation.

There are various options available for funding this cost outlined in the report. These include:

- restricting pension tax relief to 20% for all earners, raising an annual £12 billion
- reversing previously proposed corporation tax cuts from 20% to 17% could save £7.5 billion.

What is the Government doing now?

In November 2019, PM Boris Johnson announced to business leaders that he would be shelving the planned reduction of corporation tax. Instead he pledged to spend the savings on public services.

However, the Tory election manifesto failed to outline any solid plans on social care. It pledged a vague plan to "build a cross-party consensus on long-term social care funding" and only an additional £1.1 billion in funding, well short of the £12.8 billion figure outlined by the Health Foundation.

Calls for a cross-party consensus, which has not been unachievable in the past, seem less necessary for a Government that has a big enough Parliamentary majority to push through its own agenda.

So where is the big idea?

The last detailed Tory policy pledge on social care was announced by Theresa May during the 2017 election.

The idea was that people would pay for care until their assets had fallen to value of a £100,000, including their house: but payments after death could eat into any inheritance.

It was dubbed a 'dementia tax' in the press and subsequently dropped.

Ever since there has been a palpable reluctance by government to move forward on the issue.

Publication of a Green Paper on Social Care was repeatedly postponed, and is now three years overdue, originally planned for the summer of 2017, but delayed by an election, Brexit negotiations and more elections.

Despite the delays, social care still sits at the top of the PM's in-tray and his own stated priority list – so surely it can't be avoided.

Or can it?

How seriously is the government commited to the Long Term Plan?

John Lister

On January 15 the Johnson government tabled the NHS Long Term Plan Funding Bill which they argue will "protect in law" an extra £33bn every year by 2024 for the NHS to transform care. Labour unsuccessfully attempted to move an amendment to increase the amount of money. The sum on offer is clearly not enough.

The official press release states that "The bill will contain a 'double-lock' commitment that places legal duty on both the Secretary of State and the Treasury to uphold this minimum level of NHS revenue funding over the next 4 years."

However there are concerns among sharper-witted observers, such as the Nuffield Trust's Sally Gainsbury, that the amount of money being guaranteed is stated in *cash terms* only, and can therefore be vulnerable to inflation.

Indeed, as we have pointed out in the Lowdown, when it was first announced the £33.9bn figure was stated by Theresa May's government to be equivalent to just **£20.5bn** in 'real terms' by 2024.

It seems that the legal "lock" is also a means of preventing any higher sum being allocated – in other words the **"minimum level"** is also the **maximum** – so unless there is new legislation NHS services will continue to decline for lack of resources over the next five years.

New legislation

There also appear to be some doubts over the extent to which the new government will carry through the legislation called for by NHS England to create a legal framework for their so-called "integrated care systems" in the Long Term Plan.

Early last year NHS England attempted to enlist public support for proposals to scrap compulsory competitive tendering, the "Section 75" measures and regulations.

Even while they promoted these changes, NHS England continued to drive through a range of tenders and outsourcing of services including hi-tech scanning services, making it clear that their plan was still completely consistent with further fragmentation and privatisation of selected services.

It has been clear from the outset that to get rid of some of the unwanted baggage of the 2012 Health and Social Care Act and pave the way for various so-called "integrated" bodies would require legislation, which Theresa May's ministers and subsequently Johnson have until now appeared to accept.

However despite the high hopes of NHS England bosses and the apparently categorical promise in the Conservative Party Manifesto that "Within the first three months of our new term, we will enshrine in law our fully-funded, long-term NHS plan," the explanatory notes to the Queen's Speech are much less clear cut.

Evasive

Under the heading "DELIVERING THE NHS LONG TERM PLAN" the wording is vague and evasive, stressing the need for "thorough consideration":

- **In September 2019 the NHS published a set of recommendations for legislative changes that would enable the NHS to go faster and further in realising the ambitions set out in the 10-year NHS Long Term Plan.**
- **The Government welcomes the NHS's leadership of this work, and all the input from people across the health and care system and is committed to supporting the implementation of the NHS Long Term Plan.**

- **The Government is considering the NHS's recommendations thoroughly and will bring forward detailed proposals shortly. This will include measures to tackle barriers the NHS has told Government it faces.**
- **This will lead to draft legislation that will accelerate the Long Term Plan for the NHS, transforming patient care and future-proofing our NHS."**

Whether this legislation, when it eventually takes shape, will go as far or as fast as NHS England is hoping remains to be seen.

The knighthood in the New Year Honours for NHS England boss Simon Stevens, despite five years of constantly declining performance of the NHS, might suggest ministers are favourably disposed to his proposals.

Or it might be a sign that the ***HSJ*** was right last summer to suggest Stevens may be planning to step down in the second half of this year, and this is paving the way for his departure before another set of his plans begins to unravel.

High number of assaults still take place on mixed-sex mental health wards

The Health Service Journal (HSJ) has obtained figures on the number of sexual assaults reported each year on mixed-sex mental health wards in England.

The publication notes that the hundreds of assaults make it clear that investment is badly needed to protect patients and improve facilities.

HSJ figures, obtained via freedom of information (FOI) requests, showed there there was at least 1,019 reports of sexual assaults between men and women on mixed wards from April 2017 to October 2019.

In comparison, over the same time period there were just 286 reports of incidents on single-sex mental health wards.

In December 2018, Sir Simon Wessely's review of the Mental Health Act recommended changes to the definition of single-sex accommodation to ensure wards are "genuinely" single sex.

The current rules were considered to be too weak.

The 2018 review noted that the definition of 'single sex accommodation' needs to make sure that sleeping accommodation, bathrooms and daytime spaces are genuinely single sex, with optional mixed sex daytime space available.

HSJ reported that data from the FOI requests found there are hundreds of mixed-gender wards and communal areas still in use.

Of the trusts which responded, there was a total of 668 mixed-sex wards and 803 mixed-sex communal areas.

The Department of Health and Social Care has not yet changed its definition of single-sex accommodation in line with the December 2018 review, and did not respond to ***HSJ*** when asked if it would change its definition.

Charity mental health provider misled CQC

The Care Quality Commission has published a critical report on the independent mental health provider, St Andrew's Healthcare. The charity, which mainly operates in the Midlands, was rated "requires improvement".

The report contained a number of concerns, including that in previous inspections records had been falsified for the CQC thus covering up allegations of poor care and abusive behaviour.

The CQC's report states: "Patients, staff and relatives raised concerns that management may either not be aware of or are not responding to issues including poor and selective reporting, falsifying records, intimidation of staff, and active deception of [the] CQC."

The CQC also stated that "staff did not consistently feel confident to raise concerns without fear of reprisals. The provider had not afforded the appropriate protection to one staff member under The Protected Disclosures Act 2014."

In November 2019, St Andrew's was found to have unfairly dismissed a nurse after the charity discovered that they had been involved in previous whistleblowing cases at other providers and had reported concerns soon after he was employed by St Andrews. He raised concerns with trainers during his week-long induction about fellow inductees cheating on e-learning modules by screenshotting the answers.

The CQC inspectors were also shown evidence that staff who had been dismissed following abusive or threatening incidents with patients had been re-employed by St Andrews.

St Andrew's Healthcare is one of the largest charities involved in residential mental health services. Its hospitals have received a number of critical reports in recent years.

In June 2019, its Northampton hospital was rated "inadequate" by the CQC.

The watchdog had found that adolescents were kept in unsafe seclusion rooms for excessive amounts of time and without beds, blankets or pillows.

It was reported that some patients had been in seclusion for years. Earlier in 2019 the Victoria Derbyshire programme was given footage of a teenager reaching their arm through a door hatch to enable contact with their parents during a visit to the hospital.

The CQC gave St Andrew's six months to improve this service, and if it does not do so the hospital's registration will be cancelled, effectively closing the 99-bed site.

Thousands of young people rejected by mental health services

Sylvia Davidson

Tighter restrictions on access to mental health services means that thousands of young patients are being denied care, leading to a large rise in the numbers turning up in A&E; pressures that are described in a string of new crisis reports.

Over a quarter (26%) of referrals to specialist children's mental health services were rejected in 2018-2019 according to a new report by the Education Policy Institute.

Despite referrals by GPs judging that special care was needed, an estimated 133,000 children were denied care by mental health providers last year for not being suitable for treatment, or because their conditions did not meet the eligibility criteria.

The tightening of the criteria was confirmed by A ***Pulse*** survey of 935 GPs in which nearly 30% said the rules governing referrals to adolescent mental health services

(CAMHS) had become stricter in the past year.

Freedom of information replies from 29 NHS mental health trusts in England (out of 56) revealed that a third restrict care to patients with 'severe/ significant' conditions, for specialist child and adolescent mental health services (CAMHS).

According to the analysis by ***Pulse*** only one in five NHS mental health trusts accept referrals for children with mild, moderate and severe mental health conditions.

Children in areas with restricted access have to wait until their condition worsens before they qualify for treatment. in some cases this has led to children attempting suicide before their referral is accepted.

This was the case for 16-year-old Sam Grant, who was referred to CAMHS by his GP, but his referral was rejected because his symptoms did not meet the threshold of 'moderate to severe'. Sam died by suicide in October 2019.

An inquest noted the issue of the threshold criteria at Sam's local CAMHS, but also that the service had also not suggested alternative assistance.

Charities can't cope

GPs are being told to refer the young people rejected by CAMHS to services provided by charities, however they are also often struggling with the increase in demand and they rarely have psychiatrists, but are based on counselling and can not provide specialist help.

A survey by the charity YoungMinds published in early November 2019 found that over three-quarters (77%) of 1,008 GPs felt community support for child mental health problems was not good enough, and almost the same number did not feel confident that their referrals to CAMHS would result in treatment.

A&E is last resort

It is also now clear that A&E is increasingly been seen as the only option for young people in crisis, these could be those rejected by CAMHS or those on the long waiting lists for an appointment.

An analysis by The Independent of data from 2010 to 2019 found that there has been a 330% increase in children and adolescents turning up in A&E with mental health conditions.

It is true that demand for CAMHS has risen significantly, with referrals were up by 18% between 2017/18 and 2018/19 alone, according to NHS Digital data.

However, this is not a sudden rise: demand has been rising for a number of years, but capacity has not increased.

Andy Bell, deputy chief executive at the Centre for Mental Health policy think tank, told The Independent that the data on A&E visits was not a surprise:

"There has been a significant increase in demand but we haven't seen an increase in capacity.

"That will be one reason for this in that people are being made to wait longer for help and more children are reaching crisis point."

In a survey 43% of UK family doctors said they told parents whose children were struggling with anxiety, depression, self-harm or eating disorders to seek treatment privately.

Advised to 'go private'

One effect of the high number of referral rejections and the delays to getting help is the number of GPs now advising parents to seek private care for their children. In a survey by the mental health charity Stem4, 43% of UK family doctors said they told parents whose children were struggling with anxiety, depression, self-harm or eating disorders to seek treatment privately.

Many of the GPs that took part in the survey for Stem4, were highly critical of CAMHS, describing services as "dire", "extremely lacking", "non-existent" and "totally, horrifically, grossly inadequate".

In this 2019 survey 90% of GPs described CAMHS in their area as 'extremely' or 'very' inadequate, in 2016 this figure was 77%.

Driving those patients that can afford it towards private care signals the path to a two tier system, with children from poorer families being denied care or having to wait longer, potentially with worse and sometimes tragic outcomes.

Dr Nihara Krause, a consultant clinical psychologist and founder of Stem4: noted that

"Parents whose child has cancer or a serious physical health condition would never have to pay for private care, so why should it be OK for those whose children have mental health problems to be told to do that?

"This again shows that the much-vaunted 'parity of esteem' between physical and mental health services is still a far-off goal."

Providers and Royal Colleges speak out as NHS performance falls to its worst-ever level

John Lister

NHS Providers, professional bodies and Royal Colleges have been increasingly forthright in their warnings on the state of the NHS in the run-up to the election and the period immediately afterwards.

It's clear they are reflecting the growing frustration of their members and of health staff generally caught at the sharp end of a system that is being pushed to the very limits of endurance as demand pressures continue to rise, funding, staff and resources lag ever further behind, and ministers roll out inane and deceptive statements to mislead the public on the scale of the problem.

NHS Providers, which represents NHS trusts, trod a diplomatic line of welcoming statements by Boris Johnson and the Conservatives committing to improve the NHS, while also pointing to the growing gap between the amounts needed and the limited resources available. They urged ministers to get "Back to reality" in a statement following the Queen's Speech.

Its deputy chief executive Saffron Cordery argued that

"We've had a stark reminder over six weeks that in many ways it's a time of fantasy politics, with policies and promises designed to cut through to voters rather than necessarily address reality."

The reality is stark indeed:

"Performance in the hospital sector and across the urgent and emergency care pathway reached the lowest point in the 10 years since we have been monitoring the constitutional standards. And we know the pressures are just as great in community and mental health services, although not yet measured in the same way.

"In November, only 71.3 % of patients at major A&E departments were seen within four-hour waiting time target – the lowest on record.

"Bed occupancy, at 94.9%, was much higher than recommended levels. The number of ambulance arrivals over the week breached 100,000 for only the second time ever. You get the picture."

Limited funding increase

Another statement from NHS Providers points out that:

"While the commitment in the Queen's speech to deliver a 3.4% annual real-terms increase in NHS funding is very welcome … We need to be realistic about what this funding will buy and what the public should expect.

"This investment will maintain standards at their current level, but the service needs additional real investment to meet the needs of the future and deliver the improvements we all want to see."

Performance in the hospital sector and across the urgent and emergency care pathway reached the lowest point in the 10 years since we have been monitoring the constitut-ional standards

NHS Providers didn't just bang the drum for more money for hospitals: instead the demands were for improvements elsewhere in the system:

- **"a sustainable solution to the current social care crisis …**
- **"a reversal of the cuts to public health spending," with investment in prevention services, and**
- **"a move away from the hospital-centric focus," to invest in mental health, boost primary care and community services.**

NHS Providers chief executive Chris Hopson has calculated that the real terms virtual freeze on health spending since 2010 has meant that current NHS spending in England is £35 billion less than it would have been if previous average increases had continued.

But BMA chair Dr Chaand Nagpaul has pointed out in a memo to ministers that the gap will increase by another £6.2 billion by 2023 if spending is only increased by the £33.9bn cash /£20.5bn real terms increase Johnson's government has promised to enshrine in law.

The BMA's calculation is based on their view that an annual 4.1% increase in real terms is needed to keep pace with rising demand and cost pressures.

Still waiting for extra GPs

Meanwhile the Royal College of General Practitioners has opened the new year by calling the bluff of ministers who keep promising implausible numbers of extra GPs. Its Chair, Prof Martin Marshall states the service has been "running on empty" for too long, and demands a change:

"The situation in which we find ourselves has not happened overnight, and the College has been sounding the alarm bells for many years.

"Whilst workload in general practice has escalated in terms of volume and complexity, successive governments have failed to invest sufficiently in the family doctor service in order to keep pace with demand, and one consequence is that we now have a worrying shortage of GPs.

"We hope that the new Government will take this seriously and that it will deliver quickly on its General Election manifesto pledge of 6,000 additional GPs and many more thousands of the wider general practice team."

Numbers of GPs have declined by over 1,000, and numbers of GPs per head of population have fallen since Jeremy Hunt infamously promised an extra 5,000 five years ago, and the leading health think tanks warned last year that it was unlikely the shortfall in GP numbers would ever be reversed.

But it's hospital crises that tend to hit news headlines, and promises of new hospitals to be built have been prominent in ministerial claims to be prioritising the NHS, along with inflated claims to have already built 18 new hospitals since 2010.

As the i has pointed out, at least 11 of the 18 projects claimed by Johnson's ministers are not new hospitals, but "redevelopments, refurbishments or changes to existing hospital sites, such as integration or relocation".

At least half of the projects were also initiated by Gordon Brown's New Labour government, including a new Mental Health Unit at University Hospital Birmingham which opened in June 2010, a new build and refurbishment at Hope Hospital Salford in September 2011, and the new build and reconfiguration at University Hospital of North Staffordshire NHS Trust.

Will new hospitals mean extra beds?

Among those responding to this spurious claim was Dr Susan Crossland, president of the Society for Acute Medicine (SAM), who also told the i:

"Whilst investment in the crumbling infrastructure of the NHS property portfolio is of course welcome … we call into question whether this will ease the current pressures we see and we call on the government to be honest and account to the tax paying public.

"Are there going to be any more beds in the system, or are we going to continue to see further reductions which are unsustainable in the current climate?"

The SAM has reinforced calls from the Royal College of Emergency Medicine (RCEM), which has been pressing hard for more beds in the system to ease the overcrowding and crisis conditions that threaten safe treatment in A&E departments.

In January the SAM responded to the publication of the latest performance figures, warning:

"We can honestly say that acute care is facing pressures the like of which we have never seen and the huge jump in patients waiting more than 12 hours should be of serious concern to the government.

"… The target of 95% for the standard was last met in July 2015. There has been too little support, too late and the Society calls on central government to urgently tackle the shortage of beds, the lack of staff and the social care system so that hospital staff can work in a safe and sustainable system, providing world class treatment to those who need it."

Since 2010-11 attendances at Type 1 Emergency Departments in England have increased by 1.7m (12.5%) – equivalent to the workload of 22 medium-sized departments

Both SAM and RCEM are also warning that without extra capacity to deal with rising demand the ambitions of NHS England to widen the availability of "same day emergency care" (SDEC) will come to nothing.

The Long Term Plan a year ago suggested rolling out SDEC across the NHS could prevent up to 500,000 overnight hospital stays over the year.

Functioning impaired

However, an audit by the Society for Acute Medicine (SAM) found almost half (45%) of SDEC units had their "functioning impaired" by hospital trusts utilising the space as overflow for admitted patients.

Many do not provide evening or weekend SDEC services, and a report last October showing just over a third of units (35%) were only open five days a week.

"For all its good intention, the NHS's grand plan to use SDEC to improve care and capacity this winter has been grossly derailed as trusts scrounge for additional beds," said Dr Susan Crossland, president of SAM. Dr Nick Scriven, immediate past president of SAM, added: "We are increasingly concerned we will never see SDEC fully implemented as desired if units are constantly seen as the 'easy' target when under-pressure managers need extra bed spaces."

The RCEM brought a number of these issues together in its General Election Manifesto, which argued "eliminating crowding in our Emergency departments must be the number one priority."

…

"Since 2010-11 attendances to Type 1 Emergency Departments in England have increased by 1,748,283 (12.5%) – equivalent to the workload of 22 medium-sized departments. Every year, millions of people turn to our Emergency Departments as increasing numbers are living longer with a complex range of medical needs. Primary and social care services have not been developed to address this need."

Recommendations

The RCEM's recommendations to address the problems in A&E are bold – going much further than Johnson and his ministers have been willing to promise:

"1. Increase the bed capacity in hospitals to maintain flow in Emergency Departments. We estimate that at least 4,000 extra staffed beds are needed in England alone this winter to achieve 85% bed occupancy.

"2. Immediately publish a Social Care White Paper, with the view of expanding social care provision to improve patient flow and address delays in transfers of care in Acute Hospitals. Additional funding must address the £2.3 billion shortfall in social care faced by councils, as advocated by the Local Government Association."

They want ministers to "Ensure sufficient capital funding is available for trusts to transform the emergency care system at pace to ensure it is fit for purpose."

Mental health

Far from narrowly focused on hospital care, the RCEM have also pressed for urgent action to improve GP services, expand social care to support frail elderly people in their homes, and also "Build on the commitments outlined in the Forward View for Mental Health and NHS Long-Term Plan and accelerate the expansion of mental health services."

The RCEM also want urgent action by ministers to deal with the crisis their government has created with its absurd pension taxation policy, driving consultants to cut their hours.

Real anger unites Northern Ireland's health unions striking for fair pay

As we finalise this issue of the Lowdown, UNISON has just announced that it is to suspend its strikes by NHS staff across Northern Ireland, and put a new deal to a ballot. The battle for pay parity with staff doing the same jobs in the rest of the UK was supported by all of the health unions – including the first-ever strikes by members of the Royal College of Nursing.

PATRICK LAWLOR (writing here in a personal capacity), in an article written on January 7 for *Health Campaigns Together* (before the agreement was reached in talks with the unions) is a Neonatal Intensive Care Specialist Nurse Practitioner in Belfast, and Vice-President of Northern Ireland Public Service Alliance (NIPSA), whose members have also been on the picket lines.

The health service across Northern Ireland has been at crisis point for many years as a direct result of chronic and systematic policy of under-funding and pay austerity. This has resulted in £millions of pounds taken out of the health budget of the devolved Regional Assembly of Northern Ireland.

These cuts are part of Westminster Conservative austerity strategy to make working people pay for the financial crisis of 2007/8 caused by the greed of wealthy profiteers and big business.

However these cuts have been implemented without resistance by the local political parties, who fully accepted the neo-liberal agenda of public sector cuts and privatisation.

Pain

The impact of these attacks has caused overwhelming pain and suffering to both patients and staff for over 10 years. As I write, not one clinical target has been met in all main health priorities such as cancer, cardiac and emergency services and many more.

Official figures starkly show 108,582 people were waiting over a year for their first hospital appointment. That is over a third (35%) of the total number of 306,000 patients currently on hospital appointment waiting lists.

This is an all-time high for Northern Ireland, increasing by 8% in the last year.

According to local Health and Social Care Board statistics, the number of people waiting longer than a year for a first outpatient appointment rose by more than 3,000 in just three months between June and September 2019.

Official figures starkly show 108,582 people were waiting over a year for their first hospital appoint-ment. … This is an all-time high for Northern Ireland, increasing by 8% in the last year.

This is at a time when the number of people waiting longer than a year for surgery has risen from 22,638 to 25,279.

This situation has become so serious that thousands of patients across Northern Ireland have been forced to pay privately for treatment.

The overriding objective is to undermine confidence and support for a fully publicly-owned health service and to open it up to the private sector and insurance-based health system.

Tipping point

The current working environment for staff has reached tipping point of unachieveable workloads resulting in work-related physical and mental health conditions impacting many workers.

Many health workers are having to work far beyond their finish times without pay just to keep services going.

The imposition of the cuts agenda on services and pay austerity has seen a recruitment crisis unfolding over the last decade.

There are currently 7,000 vacancies across our health service of a workforce of 60,000, a vacancy rate of over 10% that is getting worse!

This has seen thousands of pounds of public money given away to private sector recruitment agencies to cover vacant posts. Public sector agency spending has surged by 160% since 2015, and estimated to hit £230 million at the end of 2019.

This disgusting and unaccountable waste of money is commonly understood by health workers as money, which could easily go a long way to resolve the recruitment and training crisis in our health service.

Parity of pay

However, it is also recognised that recruitment can only be sustained if the pay cap on wages is broken and staff get parity of pay with their colleagues across the regions of England, Scotland and Wales.

A decade of 1% pay awards has seen a divergence of pay across the National Health Service (NHS) for workers doing the same job.

On average a health worker in Northern Ireland is approximately £2000 worse off than their counterpart in other regions. It has been reported that many staff including nurses are regularly having to go to food banks to feed their families as they struggle to pay their utility bills.

This is the context that saw the explosion of industrial action by health workers spill out across Northern Ireland on the 18th of December 2019, with many of the picket lines having the quality of mass pickets.

It is not unreasonable to say the action on the 18th resulted in one of the largest health strikes across Northern Ireland since the 1980s.

It was reported 20,000 health workers (15,000 nurses) came out on strike from 12 to 24 hours

Photos from the splendid UNISON gallery on the dispute

across all areas and departments. The strike action involved all groups of workers from cleaners, porters, caterers, transport, ambulance staff and nurses.

First ever strike

It was also historic as the Royal College of Nurses (RCN) came out on strike for the first time in its 103 year existence.

This event in itself illustrates the anger and militancy of health workers. Their confidence and strength of their own power was transformed into an uncompromising approach on that day, with every staff member I spoke to across unions stating emphatically that there was no going back!

This has resulted in the RCN Executive agreeing escalating their work to rule action planned for the 8th and 10th January to strike action, with further action proposed for the 20th, 22nd and 24th February. Other unions are currently looking at these dates to coordinate action.

Keep up pressure

It is positive that some health unions have agreed taking strike action again in the coming weeks to keep up the pressure.

This action will be augmented with the likely positive results at the end of January for industrial action ballots on pay from Allied Health Professional organisations (AHP), Royal College of Midwives, Society of Radiographers and Royal Society of Physiotherapists.

Any attack on the strikes by anti-union and Conservative commentators in the mainstream media has fallen on deaf ears across working class communities

It is essential that all health unions and AHPs maintain the momentum and immediately coordinate a series of strike dates to maximise the impact.

Maximum coordination is necessary in this battle, that means not just at the top but at all levels, including cross-union committees in workplaces to ensure that the dispute is democratically controlled by health workers.

There is also a need for increased coordination when it comes to action short of strike action, to cut across any confusion that exists in multi-union workplaces.

There is also no doubt that there is overwhelming support for the health workers dispute across all communities.

Any attack on the strikes by anti-union and conservative commentators facilitated through mainstream media has fallen on deaf ears across working class communities.

This was illustrated during the strike on the 18th, when local people routinely visited picket lines to show support, many bringing coffee, tea and sandwiches etc.

It is likely, given the pressure that is being brought to bear and potential for further action, that a revised pay deal is likely to be offered and maybe accepted by staff. However, it is also recognised that this dispute is not only about pay but also staffing and the provision of gold standard health services.

A win on pay will only augment this demand and see this campaign refocus onto the defence of our publicly-owned health service and opposition of privatisation.

Useful insights on American health care that help understand issues in our NHS

The strange world of US health care offers us a combination of horror stories to remind us how much we still have to defend in our NHS, and occasionally illustrations of more general principles. A recent flurry of studies on the US system has offered us a few of each. JOHN LISTER has dug through them.

The imposition of charges for health care, and especially for hospital care, where the likely charges can be much higher, is known to deter people, especially those on low or no incomes, from seeking treatment – irrespective of their clinical need.

A recent study of the levying of daily "co-payments" for patients receiving hospital care funded through Medicare Advantage in the USA has the dual advantage of confirming the general analysis and explaining some of the obscure terminology used by the US health insurance system.

The impact of copayments

The article, *Association of daily copayments with use of hospital care among Medicare Advantage enrollees,* explains from the outset that:

> **"Cost sharing is a common technique utilized by health insurers to "share" a portion of an enrollee's health expenditures with the enrollee.**
> **"This often takes the form of a payment at the point of service (co-payment) or payment for a fixed percentage of the cost of a given health service (co-insurance). In the hospital setting, this could also be a lump sum payment at admission (a deductible), or a payment for each day in the hospital (a per diem)."**

This is useful reference, as the article delves into the arcane world of US health care, pointing out to the many of us who didn't know that Medicare (the publicly-funded system for providing care for senior citizens, introduced by Lyndon Johnson in the late 1960s) has always levied charges:

> **"The Medicare program has used cost sharing in various forms since its inception in 1965. Medicare enrollees are responsible for 20% coinsurance for physician visits and large inpatient deductibles for hospital admissions, with no cap on out-of-pocket spending."**

In other words even the part of US health care that looks most like the NHS can still be expensive for pensioners to use, and the common factor with all charges is that they deter people:

> **"The imposition of an inpatient deductible in the United Mine Workers Health Plan in 1977 was associated with a 45% decline in the probability of having a hospitalization."**

The paper explains that the fixed fee of a "deductible" is less effective as a deterrent than daily charges, which impact most on those with greatest health need:

> **"A deductible is typically exceeded during the first day of a hospital stay, leaving no financial incentive for a patient to leave the hospital earlier. In contrast, a per diem structure retains an incentive for a patient to leave the hospital throughout his or her stay.**
> **"Thus, changing a plan's benefit structure from a deductible to a per diem could mean lower out-of-pocket spending for beneficiaries with shorter lengths of stay, but greater out-of-pocket costs for hospitalized beneficiaries with longer lengths of stay, and subsequently could lead to decreased utilization."**

In practical terms the change meant that in place of a fixed cost of $376 for a spell in hospital, under the new scheme over-65s who stayed the average 4.4 days would face a bill of $726, with the cost rising each day.

The study concludes, unsurprisingly that the switch to per diem payments did reduce the level of inpatient care for older patients, and that "the financial burden of changing from a deductible to a per-diem falls heavily on seniors with longer hospital stays."

Medicare (the publicly-funded system for providing care for senior citizens, introduced by Lyndon Johnson in the late 1960s) has always levied charges

Mergers of hospitals

Another study, this time in the New England Journal of Medicine, looked at the impact on patient care of acquisitions and mergers of hospitals, which has become an increasingly common occurrence in the past decade.

Changes in Quality of Care after Hospital Mergers and Acquisitions looks at the US experience, where of course many hospitals are commercial businesses: but the merger of NHS hospital trusts and foundation trusts has become an increasingly common feature of our health service, and the clinical impact has not been fully evaluated.

The study looks at 246 hospitals that were subject to this process between 2009 and 2013, with almost 2000 hospitals which had not gone through the same changes as a 'control':

> **"we conducted difference-in-differences analyses comparing changes in the performance of acquired hospitals from the time before acquisition to the time after acquisition with concurrent changes**

for control hospitals that did not have a change in ownership."

The findings – which of course in the US have to be viewed in the context of system that (despite decades of experience) still views competition between hospitals as a way to enhance quality of care – are that there was a decline in patient experience and "no detectable" changes in readmission or mortality rates:

"Effects on performance on clinical-process measures at acquired hospitals were inconclusive. Taken together, these findings provide no evidence of quality improvement attributable to changes in ownership."

Overall the authors sum up with a negative conclusion of the impact of mergers that should stimulate some more critical thinking about the value of similar changes in England:

"These findings challenge arguments that hospital consolidation, which is known to increase prices, also improves quality."

Costs – and savings from – introducing a single payer system

A third, even more recent open-access study in PLoS Medicine looks at the costs of switching from the current US system based on private insurance and a multiplicity of insurance companies to a 'single payer' system.

The study, ***Projected costs of single-payer healthcare financing in the United States: A systematic review of economic analyses,*** usefully explains the characteristics of a single payer system, as argued for by Physicians for a National Health Program, and, as "Medicate for all", by Bernie Sanders.

The authors make clear a real single payer scheme would eliminate the private insurers, and eliminate or almost eliminate any "cost sharing" fees to access health care (fees in excess of $5-$10).

As a result it is accepted it would increase the use of health care by many of the millions who at present cannot afford to do so – while bringing down the cost.

"Key elements of single-payer include unified government or quasi-government financing, universal coverage with a single comprehensive benefit package, elimination of private insurers, and universal negotiation of provider reimbursement and drug prices.

Single-payer as it has been proposed in the US has no or minimal cost sharing.

Polled support for single-payer is near an all-time high, as high as two-thirds of Americans and 55% of physicians."

Spending on admin and other aspects of the system adds up to a staggering 30% or more of US health spending, adding up to as much as $935 billion per year.

The researchers searched the academic literature back to 1990 for articles that estimated the costs of this change, excluding studies that gave inadequate technical details or which assumed a substantial continued role of other health insurance.

They found 22 appropriately based articles: and their analysis showed a remarkable level of unanimity, in that 19 of them projected financial savings from the very first year of the new system, while 20 out of 22 "predicted savings over several years".

The main source of the predicted savings was on reduced costs and complexity of administration, along with savings on drug costs.

As we discussed in a previous Lowdown, researchers have shown that wasted spending on admin and other aspects of the system adds up to a staggering 30% or more of US health spending, with estimates as high as $935 billion per year.

Introducing their new study, the authors sum up the grotesquely expensive US system:

"Healthcare costs continue to rise, approaching one-fifth of the economy. In 2018, national health expenditures reached $3.6 trillion, equivalent to 17.7% of GDP.

Government funding, including public programs, private insurance for government employees, and tax subsidies for private insurance, represented 64% of national health expenditures in 2013, or 11% of GDP, more than total health expenditures in almost any other nation.

Higher costs in the US are due primarily to higher prices and administrative inefficiency, not higher utilization."

With such large numbers of Americans backing the idea of single payer after years of frustration with the existing system, the authors of this study are keen to get on and try out the idea which seems to have also secured overwhelming support from analysts:

"The logical next step is real-world experimentation, including evaluation and refinement to minimize transition costs and achieve modeled performance in reality."

The sooner some of these ideas can take shape in reality, the more lives can be saved and the more misery can be avoided for uninsured and under-insured Americans.

THE lowdown

Health news, analysis and campaigns.
NUMBER 17, January 31 2020

Informing, alerting and empowering NHS staff and campaigners

Imperial trust to bring 1,000 support staff back in house

1,000 low paid porters, cleaners and catering staff working in hospitals managed by Imperial College Healthcare NHS Trust are to be brought back in-house when the current five-year Sodexo contract ends at the end of March.

The Trust has decided not to put the contract out to tender again, but instead bring the staff into the Trust, with full Agenda for Change pay and conditions, initially for a year while a review takes place. The official statement says:

"we will undertake an evaluation after one year in order to decide whether to continue to employ hotel services staff directly - and bring all staff up to full NHS (Agenda for Change) terms and conditions – or re-tender the contract with a significantly amended specification."

UNISON, which brokered the deal with the Trust points out the significant pay increases from April 1:

"Employees' pay will increase from £10.55 to £11.28 an hour and they'll get sick pay from the first day they're ill. Workers will also be able to join the NHS pension scheme, which was previously unavailable to them as Sodexo staff."

The deal follows on nine days of strike action at St Mary's Hospital by members of United Voices of the World, and covers all support staff across the Trust's five hospitals, Charing Cross, Hammersmith, St Mary's, Queen Charlotte's and Chelsea, Western Eye.

Long A&E waits leave NHS vulnerable to coronavirus

The World Health Organization declared the outbreak a global emergency on January 30 after the number of confirmed cases spiked. More than 9,500 people had then been diagnosed with 2019-nCoV worldwide and at least 170 people had died in China as a result of the virus: that figure has since risen to 259.

Two cases have so far been confirmed in the UK, although a planeload of UK citizens has been flown back from Wuhan and put into isolation in a residential block in Arrowe Park Hospital.

Medical opinion differs on the threat posed by the virus which appears to be more contagious but less lethal than the SARS virus in 2003. However information is only gradually emerging and the threat could turn out to be much worse.

While people exhibiting the flu-like symptoms of the virus, which is related to the common cold, are advised to stay isolated and phone NHS 111 for advice rather than come to hospital, there is the danger that as papers like the *Daily Mail* whip up concerns among their readers some may decide to seek help from hospital A&E departments.

Long delays and crowding in many A&Es could prove a means to pass on the virus to significant numbers of patients, some of whom will already be in a vulnerable state.

The Wall Street Journal, warning of a similar potential threat in US emergency rooms, points back to the lessons from the SARS outbreak in Canada:

"A Toronto man, whose mother had come from Hong Kong two weeks earlier, went to the hospital with feverish symptoms. For 16 hours he was kept in a packed emergency department.

"His virus infected the man in the adjacent bed, who had come to the ER with heart problems, and another man three beds away with shortness of breath.

"Those two other men went home within hours but were later rushed back to the hospital, where they spread the virus to paramedics, ER staff, other ER visitors … and, later, staff and patients in the critical-care units."

We clearly don't want that type of thing happening here in Britain.

So trying to avoid panic reactions and extra efforts to ensure staff keep a close watch on all A&E patients as they wait could be vital.

IN THIS ISSUE

More stories and more detail on our searchable website

- NHS bosses discuss plans to deal with £10 billion trust debts

- Primary Care Networks – NHS England retreats under fire from angry GPs

- Children's mental health – a decade before it improves

In our next issue:

- North West London faces further cutbacks
- Poorest areas from former "red wall" constituencies could face social care cuts

Check out *The Lowdown* online

- An update on Integrated Care Systems: behind the rhetoric, how far have they really got?

- **The history of privatisation in the NHS** - part 1 of a new series

Babylon to link up with midlands hospital trust

The private digital GP provider, Babylon Health, has announced a 10-year partnership with Royal Wolverhampton Trust that aims to use technology to transform the way patients access healthcare.

The partnership claims to be the "world's first integrated digital healthcare system," and aims to create "joined up care" that allows patients to access NHS primary, secondary and community healthcare services through a single app.

The CEO of the Wolverhampton Trust, David Loughton has ambitious plans for the role of digital technology telling the Times, "I think 50 per cent of consultations could be done remotely."

Remote

The plans include remote access to GPs and hospital specialists, patient monitoring for those with chronic conditions and rehabilitation following hospital stays.

The Daily Mail reported that the "Royal Wolverhampton plans to sell the technology to the rest of the NHS if the partnership is successful."

Artificial intelligence will also be utilised to triage and provide medical information to patients, based on their symptoms.

The new partnership will provide a service for around 300,000 people across Wolverhampton and surrounding areas although David Loughton told the HSJ he does expect some flack from local GPs.

GPs don't like it

"They don't like Babylon. They see Babylon as creaming off the not very ill and [being] left with the not very fit, but you cannot possibly just stay with that view."

But he is determined to plough ahead quoting the scale of workforce challenges as a major reason for the new approach.

Babylon claims to be able to utilise a national network of clinicians to help free up local clinicians to spend more time with complex patients.

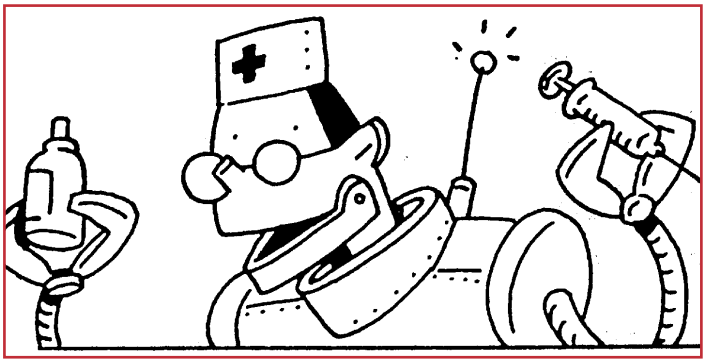
Babylon's existing services

Babylon Health has a contract with NHS England to register patients to the GP at Hand app.

The Royal College of GPs and BMA have both criticised the service for 'cherry picking' younger, healthier patients. This leaves other GP services to deal with patients requiring more complex care.

Babylon's diagnosis software has also come in for criticism. An anonymous NHS doctor who tweets under the name @DrMurphy11 has tested the Babylon app repeatedly, highlighting failures in its ability to detect potentially fatal health conditions.

More on Babylon Health from our Lowdown Q&A



New hospitals won't end bed shortages

John Lister

Management at Whiston Hospital, which only opened in 2010, have applied for permission to install a 2-floored Portakabin in the car park to provide 60 extra beds.

Whiston's A&E is the busiest on Merseyside, and the St Helens & Knowsley Trust is concerned that sky-high bed occupancy levels can lead to "inappropriate" levels of care on wards and result in a lower rating from the Care Quality Commission.

Whiston was part of a £338 million redevelopment, which also included the opening of the new St Helens Hospital. Just ten years later, having already paid a staggering £462m in unitary charge payments, and with over £2.2bn more to pay on its 42-year Private Finance Initiative contract with runs to 2048, it is too small and resorting to desperate measures to expand capacity.

According to the Liverpool Echo the planning application states that the Portakabins would be in place for "a minimum of five years" in order to "bridge the gap until the more permanent solutions, both on-site and in the community, kick in".

With no prospect of any extra allocation of NHS capital for expansion until at least 2024 this sounds like wishful thinking.

But even the six new hospitals that have been given the go-ahead since Boris Johnson took over as Prime Minister last July are already faced with the prospect of bed shortages and inadequate capacity – before a brick is laid.

One example is the new specialist emergency care hospital which is to replace most of the front line services provided from 1,048 beds by **Epsom and St Helier hospitals** in South West London. The CCG will put the decision on where it should be located out to consultation, but have already decided that their favoured option is Sutton.

Downgraded

The opening of the new hospital, which will be very much dominated by the needs of the Royal Marsden Hospital next door, will mean the both of the existing hospitals providing A&E, Epsom General and St Helier in Carshalton would be downgraded to urgent care only.

Six core (major) services, the emergency department, acute medicine, emergency surgery, critical care and children's beds for the most unwell patients, those who need more specialist care, and women giving birth in hospital would be provided only on the one new hospital site, with just 496 beds.

So even if some elective work is retained at Epsom and St Helier and bed numbers remain unchanged, the big question is how would the new hospital cope with this reduction in front line beds? And is £500m anywhere near enough to provide the mix of services proposed in the consultation?

Leicester is another one on the list of six new hospitals to be built – and another where there are more doubts than certainty on whether the plan is viable or affordable for the money available.

January's meeting of the University Hospitals Leicester trust Board heard that urgent and emergency care continues to be "extremely challenging," with a 5.4% increase in emergency admissions in November 2019 compared to November 2018.

Leicestershire campaigners protesting at the obsessive secrecy of health chiefs who have still not published their massive preconsultation document

But the last detailed plan for health care across the county, the 2016 Sustainability and Transformation Plan, called for a hefty – and unachievable – reduction in bed numbers by 243, 12.5% of the total, by 2020-21.

The most recent winter sitrep reports show that even with 82 "escalation beds" open the trust is consistently running with well over 90% of beds occupied.

In December the trust only managed to see and treat 58.5% of the most serious Type 1 emergency patients, and the lack of beds kept over 2,300 patients waiting over 4 hours on trolleys after a decision to admit them.

Since then an extensive Preconsultation Business Case has reputedly been drawn up under a total blanket of secrecy: rumour has it the document could be as much as 1500 pages long.

But it has not been released for any pre-consultation with the public in Leicestershire, quite likely because health bosses fear the critical eye of local campaigners could swiftly demolish the assumptions and wishful thinking if it were revealed.

Protests demand end to secrecy

We now have the curious situation of a looming deadline of late March to launch the full consultation (which has to precede any business case to release the funds for the new hospital), but no clarity on the extent to which reality has forced a change in the planning assumptions of 2016, and no public discussion having taken place on the "pre-consultation". Campaigners have begun to protest outside local meetings demanding an end to the obsessive secrecy.

In **Leeds t**here is little pretence that the "new" hospital will add any significant number of beds, even though the latest statistics show the trust's beds 98% full on January 19, even with 147 extra beds (almost an extra 10%) open. Most of the new buildings will simply be replacing and

upgrading what's already there.

The section on Leeds in the West Yorkshire STP in 2016 made clear the aim was to provide fewer services: "We need to encourage greater resilience in communities so that more people are able to do more themselves. This will reduce the demands on public services and help us prioritise our resources to help those most at need."

In line with this, the press release on the funding for the new development at Leeds Teaching Hospitals Trust listed the "fantastic new facilities" that the money would be used for, with no mention of any extra beds:

- expanded critical care services to support the delivery of highly specialist treatments
- brand-new, state-of-the-art theatres as part of a dedicated theatre suite for day case procedures
- a high-tech radiology department that will serve other specialties in the hospital
- one central department for all adult Outpatient services. This will be supported by the latest technologies and key services, including pharmacy
- a therapies hub
- a new facility for endoscopy services.

KONP Co-chair Dr John Puntis, who lives in Leeds told the Lowdown:

"The Leeds Health Plan as everywhere else of course envisages a reduction in hospital activity as more care moves into the community (here this is called 'the left shift'). Bed cuts were justified in the past on the basis of 'a computer model' which demonstrated our inefficiency in relation to comparator hospitals and therefore indicated we could manage with less beds.

"I could never get out of the managers how this model had been developed and tested - they just accepted it at face value.

"I don't think there would be many (if any) clinicians who think there is further scope to reduce admissions or that there are currently enough beds."

No new hospital for Herts

West Hertfordshire Hospitals Trust's long-running plan for a rebuild on the existing **Watford General** Hospital site, finalised last July, is one of the few current plans that is proposing a larger building and another 70 beds. Chief executive Christine Allen pointed out that this would not be a new hospital:

"while we recognise that some communities would like a new hospital, we have chosen the option we believe is most likely to secure funding."

The West Herts allocation of £400m is higher than the £350m that had previously been assumed to be the most that could be secured, but well short of the £750m estimated cost of a new hospital in the Strategic Outline Case.

However the money must also cover investment to retain some form of hospital services in **St Albans** and in **Hemel Hempstead**, although neither of these will have any emergency services. The Trust has 660 beds in operation this winter, plus 28 escalation beds, and was 93% full on January 19.

West Herts is also the only trust to openly mention the question of affordability: "In the meantime, we do know that the funding will be made available on the basis, as expected, that this operates like a loan and there will certainly need to be repayments."

By contrast the second London project to get the go-ahead, **Whipps Cross Hospital,** part of the giant **Barts Health** trust, has made clear from the start that it will be a new, taller building on about one fifth of the site of the present hospital, releasing the remainder of the site for housing.

Leeds Teaching Hospitals Trust lists the "fantastic new facilities" that the money would be used for, with no mention of any extra beds

A glossy promotion pamphlet showing futuristic buildings makes no mention of bed numbers but it's highly unlikely the new building will have any more beds than Whipps now has to deal with its large catchment population in Waltham Forest and surrounding NE London boroughs and parts of Essex.

Harlow's Princess Alexandra Hospital (PAH) seems to be one of very few completely new hospitals on the list of new projects: the Trust Board decided after a public meeting last autumn that it did not want to attempt to rebuild on the existing site, but to build on a greenfield site by Junction 7A of the M1.

PAH chief executive Lance MCarthy warned the Board that the new hospital is unlikely to be open until 2025, and that the Trust itself does not have "the required skillset for a project of such size" – so will no doubt be in the market for management consultants as an additional resource to fill in the gaps.

There are still no details on the likely size of the new hospital, although earlier plans have included a 424 bed hospital with a total of 633 "care spaces". The current one with almost 400 beds is consistently over 90% occupied even with an extra 24 escalation beds open.

Not enough cash

These six newly authorised projects are not the only ones with management wondering if the money they have been allocated is enough to pay for the new buildings they need.

In **Shropshire** the projected cost of the 'Future Fit' plan, to downgrade services at **Telford Hospital** and "centralise" emergency and specialist services in **Shrewsbury** has increased by 60%, from the £312m that has been allocated to an eye-watering £498m. Campaigners reckon local health chiefs have probably known for years they'd got their sums wrong – but chose to keep it quiet.

So while ministers continue to boast of the limited extra funding they will be giving the NHS after a decade of real terms cuts, the question is how far short this extra funding will fall, and how trusts desperate to renew crumbling buildings and clapped out kit can draw up realistic plans to deliver adequate capacity for decades ahead – and find the cash they need to make it happen.

Luton hospital unions fight to get services in-house

Luton and Dunstable FT management have clearly learned nothing from the five years of erratic services they have had from private contractors Engie since they decided to put cleaning and catering services out to tender.

Services which had been consistently rated at 99% when delivered in-house have since 2015 required repeated trust intervention and "remedial" action.

Trust bosses have already made clear they don't want to extend the Engie contract, but with the contract due to expire later this year they have also ruled out the obvious option of bringing the services back in-house, claiming this would increase costs.

Instead they are proposing to invite bids for a ten year contract to deliver an increased range of services for a pathetically low £55m per year – while Engie managers have told the unions the realistic cost would be more like £80m.

UNISON and GMB have launched a determined campaign to force the trust to change course and bring services back in-house.

A lively meeting on January 30 kicked off the campaign, publishing a report *Quality Pays* by Lowdown co-editor John Lister, making the case for bringing the outsourced services back in house.

A board outside the hospital proclaims the trust's commitment to "clinical exellence, quality and safety."

Will the trust dump these values for short term savings?

Mansfield Commission members Dr Stephen Hirst (left), John Lister (centre) and Michael Mansfield QC (right), with council leader Steve Cowan (behind), and campaigners Jim Grealy and Merril Hammer at the ceremony on January 22.

Borough honours campaigners for rescuing Charing Cross

The London Borough of Hammersmith and Fulham has given its highest civic honour of Freedom of the Borough to three of the leading local campaigners who fought so hard and for so long to defeat plans for the closure of Charing Cross and Ealing Hospitals.

The same award has also been given to the three members of the independent commission led by Michael Mansfield which, in a series of hearings in five of the NW London boroughs affected, reviewed the Shaping a Healthier Future plan and exposed its lack of evidence and viability.

The Commission helped ensure the plan was eventually axed by Matt Hancock last year, lifting the threat to both hospitals.

German based company pulls ahead in south London pathology bid

The German company Synlab has been announced as the preferred strategic partner for a pathology contract worth £2.25 billion over 15 years. The contract covers a large chunk of south east and central London.

The incumbent provider Viapath, a company jointly owned by Serco, Guy's and St Thomas' Foundation Trust and King's College Hospital FT, has held the contract since 2009.

The other unsuccessful bidder was HSL, a partnership between the Australian company TDL, University College London Hospitals NHS FT, The Royal Free London FT and North Middlesex University Hospital.

The contract covers the provision of pathology services to South London and Maudsley FT, Oxleas FT, the Royal Brompton and Harefield FT, and to Guy's and King's FTs, the two trusts who jointly own Viapath. The boards at Guy's and King's FTs will now have to approve the appointment of Synlab.

If Viapath loses this contract, the company will have no significant NHS contract. Synlab, which, with was bought out by British-based private equity group Cinven in 2015, operates in the UK as the wholly owned subsidiary iPP (Integrated Pathology Partnerships).

iPP was set up in 2010 specifically to seek partnerships with the NHS, and is involved in Southwest Pathology Services and Pathology First.

The latter is a collaboration between Basildon and Thurrock University Hospitals FT and Southend University Hospital FT which provides pathology services across south Essex.

If Viapath loses this contract, the company will have no significant NHS contract.

In the same week as the London announcement The *Health Service Journal* reported that The West of England Pathology Network – which comprises acute NHS trusts in Bristol, North Somerset and Gloucestershire - has rejected proposals from NHS Improvement (NHSI) to centralise laboratories in the region.

When asked to rate seven proposals for redesign, the members of WEPN rated the NHSI proposal as lower than the "do nothing" option.

The WEPN will now explore three other pathology reconfiguration options. The highest scoring option was a "virtual hub", in which the network centralises some specialist testing, and possibly IT and/or training, but with all laboratories remaining in use.

NHS England has been encouraging the redesign of pathology services for over a decade, and although it did not explicitly advocate private company involvement this has led to a large amount of privatisation.

In September 2017, NHS Improvement reiterated calls for the development of pathology in line with the 'hub and spoke' model and its plans to create 29 pathology networks across England in a bid to save £200 million by 2021.

By November 2019, 16 of the regions had formally agreed new models, up three from September 2018, but 13 have yet to formally commit to new pathology models. It also appears that some trusts which had formally agreed on a model last year, no longer do so.

False economy of cutting public health and preventive services

Sylvia Davidson

Cuts to the public health budget of local authorities are putting the government's goal of a smoke-free England by 2030 at risk, according to the new report - Many Ways Forward - from Action for Smoking and Health (ASH) and Cancer Research UK.

This annual survey of local authorities found that due to cuts, a third (31%) no longer provide a specialist stop smoking service, and three quarters (74%) say that budget pressure means that their stop smoking services are threatened.

Cuts to public health budgets mean that spending on stop smoking services and tobacco control fell by 36% from 2014/15 to 2018/19, according to the report.

The survey also looked at what was provided around England for those trying to give up smoking. In a quarter of local authorities GPs did not prescribe any nicotine replacement therapy (NRT), despite guidance that to give smokers the best chance of quitting they should be offered a combination of NRT or the drug varenicline, in conjunction with behaviour support.

Of the local authorities that still had specialist stop smoking advisors, 21% had advisers that had had less than two days training, which ASH notes is not adequate training in line with nationally recognised standards to give effective support to smokers.

One in ten

One in ten local authorities only offer a stop smoking service via primary care and these services are the least likely to be targeting groups with a high prevalence of smoking, although ASH notes that this is key if the inequalities in smoking are to be addressed.

There are also 2% of local authorities that only offer stop smoking support by telephone.

ASH and Cancer Research UK say that cuts to the budget need to be reversed if prevention targets are to be achieved, but also advocate a "polluter pays" strategy: Deborah Arnott, Chief Executive of Action on Smoking and Health (ASH) said

"To fund the support smokers need to quit, the Government should impose a 'polluter pays' charge on the tobacco industry which could raise at least £265m annually.

"This could adequately fund stop smoking services, local authority enforcement against the illicit tobacco trade and underage sales, and adequately funded public health campaigns to reduce smoking."

False economy

Although focused on anti-smoking services, the survey is yet another example of how budget cuts are setting back plans to improve the health of the population. In the long term, skimping on such services does not add-up financially - according to Cancer Research UK, smoking is the biggest preventable cause of cancer and every year smoking related illness costs the NHS £2.5 billion.

Indeed overall, ASH calculates that smoking in England costs society £12.5 billion each year, costs include healthcare, social care costs, house fires, and loss in productivity. Yet the entire budget allocated to local councils for public health is only £3.1 billion and a small and reducing proportion of this is allocated to smoking cessation. Since 2014, the public health budget has fallen by £850 million.

"To fund the support smokers need to quit, the Government should impose a 'polluter pays' charge on the tobacco industry which could raise at least £265m annually."

Inequality

In late 2019, a report from the IPPR compared those public health cuts in the most and the least deprived ten local authorities, and showed that the absolute cuts in the poorest places were six times larger than in the least deprived.

In relative terms, the poorest ten places have lost approximately 35p in every £1 of their budget, compared to the least deprived areas where approximately 20p in every £1 of their budget has been cut.

When individual services are considered then it's smoking services, drug and alcohol services and sexual health services that have taken the brunt of the cuts, according to the IPPR, down 85.1%, 260.9% and 196.4% from 2014/15 to 2019/20 spending levels.

Charities have called upon the government to increase the funding allocated to public health by £1 billion to bring it back to the 2014 level, without this the government's aim to prevent ill health and increase the number of years spent in good health outlined in the long-term plan in 2019 will be impossible.

Although the government signalled that there will be a real term increase in money for public health in its provisional local government finance settlement for 2020/21, the Local Government Association noted in late December 2019 that the settlement includes no information about the national total, or individual council allocations, of the public health grant for 2020/21.

The LGA called on the government to provide councils with clarity on the funding available in 2020/21, saying the delay to the announcement is making it extremely difficult for councils to plan effectively.

Worse services in poorest areas

NHS policies speak of reducing inequalities in health, but there is growing concern that welfare and social care spending cuts are causing inequalities to widen.

Now a new report from the Nuffield Trust points out that the same contradiction applies to health care: "There is also evidence that the Inverse Care Law is persisting in primary care. … This may be affecting deprived areas to a greater extent, resulting in a double deficit, where people in these areas have greater needs but also poorer access."

CSUs hit by CUTS

Nicola Redwood

David Cameron and George Osborne as part of the general election campaign in 2010 repeatedly pledged that there would be no more of the tiresome, meddlesome, top-down reorganisations that had dominated in the NHS in the previous decade.

Later that year, a white paper came out, Liberating the NHS, and it became clear this would become the biggest top-down reorganisation in the NHS had ever seen. So much for that pledge

At the time, I was working in IT for Greenwich Teaching PCT and a Unite Workplace rep. Then came the provider split. I was involved as Staff Side Chair in endless meetings whilst decisions were made on our future path.

I ended up in an IT role in NHS South East London PCT cluster after the biggest and most complex HR transition change management I'd ever been involved in as a rep.

It was a difficult time and we lost quite a few people in the process through redundancy or resignation. I never wanted to go through anything like that again.

But on 1st April 2013 I found myself working for something called a Commissioning Support Unit (CSU) when the Health & Social Care Act came into law.

CSUs are a little-known part of the NHS. 19 CSUs were set up in 2013: there are now only five.

In 2013, CSUs employed over 9,000 staff: this has fallen to around 7,000. They are "arm's-length" bodies of NHS England. Our legal employer is NHS Business Services Authority.

CSUs offer little information to the outside world about how they operate, their purpose or their decision-making process. Their purpose is to provide advice and back office functions including recruitment, HR, Finance and IT to Clinical Commissioning Groups (CCGs).

Core business

IT contracts for CCGs and GPs are core buiness for CSUs. The more significant role of CSUs is the role they play as the door through which the private sector is brought in without public scrutiny: the 2013 NHS England document ***Mapping the Market*** listed 23 private companies that could be involved in the work, and noted:

> "Although CSUs and independent sector providers are still finding their place in the market, at present, there is an emerging trend of independent sector providers working through CSUs to provide commissioning support rather than working directly with CCGs."

CSUs don't produce annual reports or financial accounts like other statutory NHS organisations. Working for a CSU is completely different to working for any other part of the NHS, and there is almost no transparency.

As a union rep, my role certainly isn't made easy. I work in a small team providing IT support (servers) to CCGs and GP practices across South London. However with so many reorganisations, in-housings and TUPE transfers there are times when I'm doing my day job less than I'd like.

My part of the NHS has seen more top-down reorganisation than I ever want to see again in a lifetime.

Fast forward to today. The mental health of staff and a blame culture are key issues every year in our NHS Staff Survey results.

We're now seeing another big change in the NHS in England, part of the sustainability and transformation plans. CCGs are merging in STP footprints right across England in 2020 and 2021 to pave the way for them to become Integrated Care Organisations (ICOs).

The NW London STP has been discussing derecognising trade unions, and there is little partnership working with unions. Each reorganisation experience is getting more painful and many of the good people are going.

December 2019 saw yet another consultation on reorganisation, due to yet another round of 20% cost efficiency savings needing to be made by CCGs.

This has a knock-on effect on CSUs, which get most of their income from CCGs. My CSU has lost multiple contracts, mostly in IT, leading to a significant financial challenges.

239 staff out of a total headcount of 1,574 are potentially at risk of redundancy. This is in the context of a still too-high spend on interim and agency staff.

We won't know for a few months how many jobs will be lost in total across the CCGs and the CSU: it is likely to be between 100 and 200, but could be lower.

For the CSU, this is a complex reorganisation with many transfers in and out to be consulted on separately. My own team is being cut by half, with a proposal to move us out of London as well

Evidence shows that constant change causes instability and poor performance, and morale is extremely low.

This is accompanied by a rise in the number of employment relations cases and sickness absence putting even more pressure on us union reps.

Enough is enough. With an unprecedented number of disputes across the NHS in the last 12 months, and services being decimated by cuts, NHS workers need to stand together as a collective and fight back.

Inquiry will scrutinise NHS implementation of migrant health charging

Tony O'Sullivan

A new panel of inquiry has been set up by Lewisham & Greenwich NHS Trust (LGT) to investigate the implementation of 'overseas charging' policy at the trust and the trust's partnership with credit checking company Experian from 2013 to 2019.

The revelation late last year that the deaths of three mothers in the UK have been linked to the Government's migrant charges policy places a heavy weight of responsibility on the inquiry, knowing that the lives and health of patients are at stake.

This inquiry is important and probably the first of its kind. It is a welcome development and a direct result of campaigners from the Save Lewisham Hospital Campaign (branch of Keep Our NHS Public) challenging the trust on why it was responsible for referring a higher number of invoiced to debt collectors than any other trust in England.

Unable to pay

Last March *The Guardian* reported on NHS patients who had been unable to pay invoices often amounting to thousands or tens of thousands of pounds, and referred to debt collection agencies in England.

In LGT's case, it passes on unpaid invoices to the joint venture company, NHS Shared Business Services (SBS).

Between 2016 and 2018 1,085 unpaid LGT patient invoices worth £5.4m were passed on by SBS to debt firms CCI and LRC. This was the highest in England. And yet only £88,000 was recovered – a mere 2% - a sign many would say that the scheme was more a part of the hostile environment than a rational policy.

Campaigners had also questioned the trust on the link between its partnership with Experian and the high number of patients identified for invoicing.

Before they could get an answer, the *HSJ* disclosed in September that NHS Improvement had suggested to 51 NHS trusts that they might approach Experian, to copy the LGT scheme.

This proposal from the regulator to extend data-sharing on an industrial scale was unaccompanied by any legal advice on the lawfulness or ethics of the scheme.

Question over legality

Lewisham & Greenwich Trust was forced into the limelight when a report in a south London newspaper questioned whether LGT's large-scale data-sharing was ethical or lawful, and quoted MedConfidential's questions highlighting LGT's partnership with Experian,.

To be clear, Experian was not doing credit checks on patients. But it was using its database to process large batches of NHS patients' data in order to confirm who had an 'economic footprint'.

Experian was not doing credit checks on patients. But it was using its database to process large batches of NHS patients' data in order to confirm who had an 'economic footprint'.

They relied on that as 'evidence' that those with footprints were ordinarily resident in the UK, and assumed to be entitled to NHS care without charge. The trust excluded them from further challenge, and focusing on patients without such a footprint – even though this is in many cases linked to poverty, lack of bank account, credit cards etc.

The trust has responded positively following these revelations and has set up the panel of inquiry into 'Overseas Charging', headed by an independent chair and with campaigners on the panel. LGT has now told the HSJ they will no longer use Experian.

Director of Integrated Care and Development at LGT Jim Lusby argued the trust took the decision to carry out checks on everyone "in order to avoid discrimination," but has now said "In hindsight it was not the right choice. In all honesty I struggle to defend the logic of this",

In fact the government's own MESH database can now offer virtually the same functions as the Experian checks.

Scrap charges

Nationally, the call to scrap the migrant charges scheme is gaining in strength, backed by the Royal College of Midwives, the BMA and the Association of Medical Royal Colleges (AoMRC).

Public campaigning will continue outside of the Lewisham panel, which will be looking at how these policies might threaten access to prompt and safe clinical care if patients are fearful of approaching NHS services lest they receive unpayable bills and are referred to the Home Office.

Mothers have even been invoiced following stillbirth or miscarriage. Locally and positively, the trust has changed policy on this. But across the land patients have been scared away from services they need.

The outcome from the Lewisham inquiry could not only lead to safer and more compassionate practice but crucially also add weight to the call to repeal these oppressive laws.

4-hour A&E target saves lives – official

John Lister

Performance in England's A&E departments has fallen to new lows after a decade of under-funding and real terms cuts in spending alongside an increased population and a rising proportion of older people.

The target of treating or discharging 98%, and later 95% of A&E attenders within 4 hours has not been reached by England's NHS since 2015. So ministers such as Matt Hancock, despairing of ever regaining the consistently high performance levels achieved in the late 2000s, have looked to ditch the embarrassing target – effectively moving the goalposts – rather than tackle the underlying lack of resources.

The Royal College of Emergency Medicine is one of a number of professional bodies that have challenged Matt Hancock's apparent wish to ditch the 4-hour target that is enshrined in the NHS Constitution. Dr Katherine Henderson, the president of the RCEM said:

"So far we've seen nothing to indicate that a viable replacement for the four-hour target exists. Rather than focus on ways around the target, we need to get back to the business of delivering on it."

Susan Crossland president of the Society for Acute Medicine, which represents specialists in hospital care of the very sick, put it more bluntly: "Potentially scrapping the target because it is no longer being met shows the disregard this current government has for improving patient care."

Crucial

The Royal College of Physicians, stressed that the target had "played a crucial part in driving improvements in waiting times for patients," and the BMA has also spoken out against dropping or diluting the target.

The RCN's Emergency Care Association, representing 8,000 A&E nurses, told the HSJ that "it could cause significant detriment to patient safety within our emergency departments if the four-hour target was abolished."

The problem in A&E is not the large numbers of minor cases, so-called "Type 3" A&E attenders, who might otherwise have been treated by GPs or by nurses in an urgent treatment centre: almost all trusts consistently treat and discharge close to 100% of them within the 4 hour target.

Instead, perversely, it is those with the most serious health needs, the Type 1 patients, who face the greatest delays, mainly for lack of beds to admit them to hospital.

But Britain is not alone in struggling to deliver prompt emergency care: according to a new study recently published by the Institute of Fiscal Studies:

"there remains dissatisfaction in most health care systems with the level of crowding in EDs and the speed with which cases are resolved."

What was unique to England's NHS was the imposition of the 4-hour target: but while those embarrassed by performance figures like Hancock try to argue it is now out-dated and clinically inappropriate, the IFS report, researched jointly with Cornell University and the Massachusetts Institute for Technology (MIT) shows that it has brought significant and tangible benefits to patients:

"We study one type of regulatory intervention, the four-hour wait target policy enacted in England. We find that this target had an enormous effect on wait times …
"We find this target led to a significant rise in hospital admissions. …
"At the same time, we find striking evidence that the target is associated with lower patient mortality. There is a 0.4 percentage point reduction in patient mortality that emerges within the first 30 days, amounting to a large 14% reduction in mortality in that interval. …
"While modest, this effect is large relative to the extra spending…
"Finally, we … show that this effect arises through reduced wait times, not through increased inpatient admissions." (p29-30)

The researchers find that the target creates a characteristic – and apparently unique – "spike" in numbers of admissions as the 4-hour target grows closer, with more than 10% of patients being admitted in the final 10 minutes before the deadline is reached.

"This spike is unlikely to naturally occur, and is instead induced by the target. We cannot illustrate the absence of this spike prior to the wait times target, since we do not have systematic data available from that period. But it is worth noting … that such a spike is not present in data on ED wait times from a major U.S. hospital." (p11)

The researchers estimate that the target has been successful in reducing average waiting times by around 20 minutes.

Increased admissions

It's clear from the figures that one impact of this has been to increase the numbers of patients admitted, including some with relatively minor needs, and as a result increased spending and marginally increased average costs of A&E services (by an estimated 5% or so)

However the tangible health gain flowing from the reduced waiting times is a new finding from the research. One of the research team, George Stoye, reports in a summary of the paper that:

"The target also led to large reductions in the number of patient deaths. Patient mortality within a year of visiting A&E fell by 0.3 percentage

"Given the large number of A&E patients affected by the target each year, these estimates imply that the target resulted in around 15,000 fewer deaths in 2012-13 alone."

points among the patients affected by the target, reducing the probability of mortality among this group from 9% to 8.7% as a result of the policy.

"Given the large number of A&E patients affected by the target each year, these estimates imply that the target resulted in around 15,000 fewer deaths in 2012-13 alone."

The paper goes on to ask the question of whether it is lower waiting times or the fact that more patients are admitted to hospital that saves lives?

Importance of waiting times

Some complex statistical comparisons produce evidence that larger mortality reductions flow from the reduced waiting times: there is no relationship between numbers of admissions and deaths.

It also shows that the biggest reductions in mortality rates are among patients with potentially serious conditions that benefit from timely treatment, with the largest impacts found among sepsis, heart attack and stroke patients:

"By contrast, there is no impact on patients with a number of different cancers, serious conditions which are less time-sensitive…"

In addition to researchers shoot down any suggestion of simply "fast-tracking" patients with the most serious and time-sensitive conditions:

"There is often confusion over the exact diagnosis of patients upon arrival, and identifying which patients are covered by the target might not always be obvious (and could even lead to hospitals 'manipulating' recorded diagnoses to better hit the target). Indeed, the current policy appears to be so effective because it means that patients who should be treated quickly – but who are not diagnosed or treated as quickly as they would optimally be – are treated faster."

In other words simply fast-tracking treatment of patients with specific conditions but not others "risks losing the benefit that the current policy provides for hard-to-diagnose patients."

The unexpected intervention of the IFS, with its reputation for impartiality and reliance on solid figures, further strengthens the hand of the professionals before the real showdown with Hancock when the results of the ongoing "review" are revealed.

Safety warnings amid increase in "corridor nursing"

The chronic and continued shortage of front line acute beds in NHS hospitals, with times of highest demand not restricted any more to the winter months, there has been a growing trend of hospital management to nurse patients in corridors, despite warnings from the Royal College of Nursing.

"Patient safety is being compromised too often at present," according to Dave Smith, Chair of the RCN's Emergency Care Association.

He told Nursing Notes "Having to provide care to patients in corridors and on trolleys in overcrowded emergency departments is not what we came into nursing for. It's not just undignified for patients, it's also often unsafe.

Perhaps it's no surprise to find that the RCN's focus is on the numbers of nurses ("this problem isn't going to go away unless we can increase the number of nurses in the health service.") rather than the supply of sufficient beds in properly-appointed wards, as argued for by the Royal College of Emergency Medicine. It's hard to see an increase in staff on its own being sufficient to get patients off trolleys.

The continued increase in average bed occupancy levels, and the much worse performance on waiting times for the more serious Type 1 A&E patients, many of whom have to wait for beds long after the decisions to admit them point to this as the underlying problem, although obviously more beds without sufficient nursing and other staff to care for the patients is no solution either.

Nursing Notes also reports on the email sent by an advanced nurse practitioner in Grimsby Hospital begging senior trust management to come in at a weekend and "see for themselves how unsafe it is."

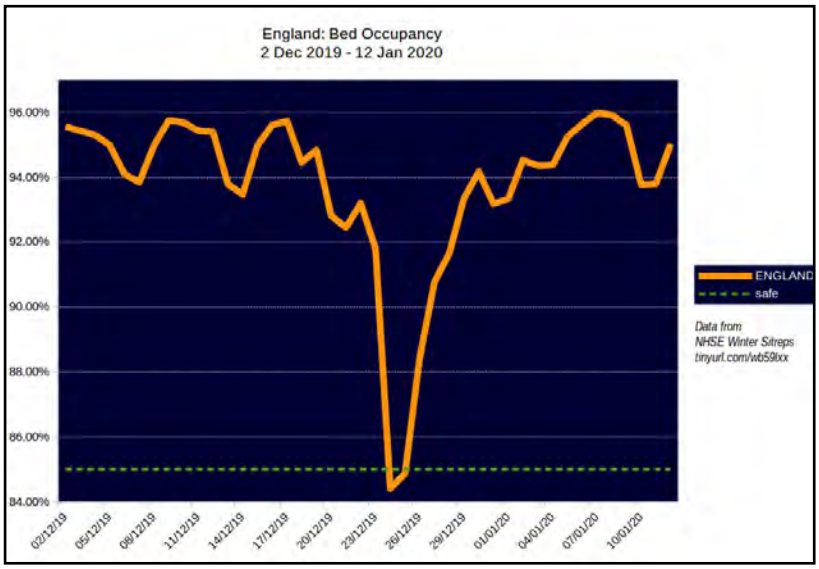
Her letter powerfully describes a situation which many A&E staff will find familiar:

"Your hospital is full – your A&E department is overflowing. But no further staff have been provided in A&E.

"You are concentrating on urgent treatment care and minors – this really is not the issue and if you continue to focus in this area someone will die.

"You are expecting staff to manage treble the number of patients in majors and resus that they would do normally, without breaks, this is not safe.

"They cannot provide that care – which is evident. The staff are trying their hardest and working to actual breaking point."



Graphs like this depicting performance for England and many of the regions are now available from Health Campaigns Together

This is a new feature in the Lowdown, in which we invite observers and campaigners to air their views on an NHS-related topic of their choice

Don't employ a politician

Guest column by ROY LILLEY

It's simple enough; you employ someone, they do a good job, a bad job, an indifferent job.

You keep them, sack them or train them.

It's not rocket science. It's the way of the world.

Harsh? Maybe. Perhaps there are reasons why someone doesn't do the job as well as you'd expect.

Lack of resource, training, opportunity, rules, regulations. Yup, I get that.

You're the boss and you have to fix it.

Yes, you are the boss and in this case, you are not running a business, you are an elector. You voted. You are running the country.

You have the outcome you like or don't like… that's democracy.

For the next five years you employ a government to keep the nation safe, care for the ones that have trouble caring for themselves and encourage us all to do our best.

Our money, your money, all our money employs members of parliament to run the nation.

What do we need to be fixed? What are the issues we want them to address?

I inhabit the world of the NHS. That's my locus. So, I want to see the MPs we employ, in the DHSC, fix some important issues. I could list about twenty mission critical things but, in the spirit of the first TV management guru, Sir John Harvey Jones; organisations should only concentrate on three things at once.

We need to solve three problems; social care, workforce and a safer NHS.

Let's have a look at them in turn.

The awful state of adult social care is a disgrace… probably a crime.

Local authorities, who have had their budgets shredded, in consequence, have raised their eligibility criteria for providing help, so high an Olympic pole vaulter couldn't get over the bar, never mind yer-granny.

There are 900,000 frail, vulnerable, elderly people, who used to get help, no longer do so. They wander around, like refugees, in our system and guess what? They pitch up in A&E, get transferred to a ward and stay there because no one can fund the care packages to get them home safely and timely.

I thought we employed MPs to fix that?

The obvious solution… we are all going to get old, so we all put a couple of quid in the tin. If we are lucky, we never have to take our couple of quid out of the tin. If we are not… there's money in the tin… don't worry.

It's called socialism. Don't be afraid to use the word. Community solidarity. You and me, looking after us.

We employ MPs to make sure we can look after us…

Workforce?

Neglect, underfunding, poor planning, the end of the training bursary for nurses… there's a list of reasons why we are in a mess. We don't have enough people to look after the people we need to look after.

Here's the big issue; there is a global shortage of care workers. A careful and thoughtful policy, to encourage qualified staff from outside the UK, to come and work here depends on a sensitive and sensible immigration policy.

A policy that is welcoming, creates opportunity, security and a future that is at least as good as the countries who are facing the same issues and have their policies sorted.

A training offer that makes working in the NHS attractive and rewarding, a reason for people to stay and the ones who have left, return.

We employ MPs to make sure we can resolve workforce issues.

A safer NHS?

No one comes to work in the NHS to do a bad day's work, to make an error, to be neglectful…

… but, a lot of people come to work and get distracted, frazzled, tired and make honest errors.

For fear of oppressive regulation, penalties and career annihilation, the errors get over-looked, covered up, ignored.

There is little learning from errors. There are few opportunities for NHS people to be frank about their actions or feelings. Why what happened, when it did.

We employ MPs to make sure there is a workplace environment that is calm, caring, supportive and a place to learn.

Three critical things and three opportunities for MPs to shine, make change, have ideas, innovate, and be supportive.

Three things that in my, over, 30 years in the NHS, the political classes have not delivered on.

Frank Dobson, when he was secretary of state for health, kicked a review of social care into the long grass. It's stayed there.

Successive health bosses have failed on workforce planning, and Jeremy Hunt, for all his bravado about a safer NHS, never dealt with safe staffing in the NHS.

Lack of resource, training, opportunity, rules, regulations?

MPs can change any of this.

If a barrier is too high, they can lower it. If training is needed they can make it happen. If regulations are too restrictive, they can change them. We employ MPs to do the people's work. Alas they don't.

For fear of party loyalty, electoral failure, criticism, challenge, making an effort, understanding or climbing the greasy pole.

The history is irrefutable… the moral of this story? If you want something done… don't employ a politician.

■ Roy Lilley's online newsletter carries comment and links to a wide variety of stories. Sign up here

THE lowdown

Health news, analysis and campaigns.
NUMBER 18, February 14 2020

Informing, alerting and empowering NHS staff and campaigners

Inquiry into chronic system failures at East Kent Trust

Family handout

Harry Richford with his parents: his death was avoidable.

With a major investigation still continuing in Shropshire, examining hundreds of potential failures of maternity care, yet another hospital Trust is under investigation for chronic failures in maternity care, resulting in loss of life. And as so often seems to be the case poor quality care and a toxic management culture have been linked with low levels of investment, staff shortages, poor morale and bullying.

It took a prolonged campaign by the family of baby Harry Richford, who died at Queen Mary the Queen Mother Hospital in 2017, to even secure a proper inquest.

And it's the findings of that 3-week inquest that his death was "wholly avoidable" that have finally forced ministers to call an independent inquiry into the chronic failure of health care and management at the East Kent Hospitals Trust's maternity department.

According to the BBC, 26 maternity cases at the Trust going back to 2011 are already being investigated by the Healthcare Safety Investigation Branch, amid fears of at least seven preventable baby deaths since 2016.

Morecambe Bay

The new inquiry is to be headed by Dr Bill Kirkup, who chaired the 2015 inquiry into maternity service failures at Morecambe Bay, and who was one of the witnesses criticising the East Kent Trust at the inquest. Key lessons of that inquiry have plainly not been learned in East Kent.

Chief Executive Susan Acott, who had consistently tried to minimise the scale of the problem, despite a coroner's ruling last month that Harry Richford's death resulted from neglect in the maternity unit of East Kent Hospitals NHS Trust, was accused of being "in denial" by Harry's grandfather Derek Richford.

Repeated early warnings of problems had been ignored, including a damning report by the Royal College of Obstetricians and Gynaecologists back in 2015

He had had to battle for six months even to get the Trust to report Harry's death to the Coroner, and told BBC Radio 4's Today Programme that a so-called "root cause analysis" report by the Trust, signed off by the Medical Director, had concluded there was no need for the Coroner to be called in.

No resignations

In the event the coroner identified SEVEN serious failings by the Trust. Expert reports commissioned by the Coroner on midwifery, obstetrics and paediatrics all found multiple failures, pointing the finger not just at the professional staff but also at the system of care and the Trust's senior management, who have refused to resign, despite being urged to do so at the Board meeting by public governor Alex Lister.

Worse still there repeated early warnings of problems had been ignored, including a damning report by the Royal College of Obstetricians and Gynaecologists back in 2015, which revealed that senior medical staff frequently failed to turn up for evening and weekend shifts at the Margate Hospital, and junior staff had seen little point in reporting this or other safety concerns because management had done nothing in response to previous reports.

Junior staff were fearful of harassment and intimidation, and noted that even where safety errors were reported no action was taken by the trust.

Nor have the Care Quality Commission come well out of this: in 2016 and 2018 their inspections rated the Trust "requires improvement" on four of the five standard criteria, but there has apparently been no further follow up and the CQC seems not to have seen or received the RCOG report until January last year.

● **Kent & Medway STP seeking £820m capital – p2**

IN THIS ISSUE

Kent and Medway seeking £820m for capital projects

John Lister

Enormous gaps in staffing, availability of capital and revenue funding seem set to stymie long term plans set out in the Kent and Medway 'Strategy Delivery Plan' published this month in board papers for the troubled East Kent Hospitals FT.

Since the Trust has not even made it onto the "long list" of 21 given seed funding to plan for new hospitals in five years' time, it is astounding that the plan admits to including a "suite of projects" ("ranging from £500,000 to £363 million") requiring a total of £821 million (p72).

The HSJ now reports that these figures include huge increased estimates for the cost of rebuilding the William Harvey Hospital in Ashford – from £160m in November 2017 to £351m now. The projected cost of an alternative scheme for a new hospital in Canterbury (which seemed to have won support from Boris Johnson in an unguarded remark at last

year's Conservative conference, later denied) has risen from £250m to £363m.

Back in 2016 most of the 44 Sustainability and Transformation Plans were characterised by huge and unrealistic requirements for capital investment, totalling £14.3 billion, when it was widely recognised that nothing like that amount would be available.

Now Kent and Medway, which then included no capital requirement in their STP, have set out their demands, which if replicated in all 42 areas responding to the Long Term Plan could stack up to well over £34 billion.

However there are other worrying aspects of the K&M plan.

It admits (p75) to dire workforce shortages in primary care (among the most severe in the country, with 25% of GPs and 55% of general practice nurses approaching possible retirement) in mental health (with a required total growth in the mental health practitioner workforce of 1577 FTE by 2024 – an increase of 50%, including including psychiatrists and nurses).

● **The full length version of this abridged article can be found online at *https://lowdownnhs.info.***

The new hospital is just one element of Kent & Medway's mid/long term plan

The submission to NHS England lists investment adding up to a hefty £637m:

- Stroke services Reconfiguration - **£27.7m**
- East Kent Acute Redesign - Option 1 = **£351m**, Option 2 =**£363m**
- Acute bids - **£224m** (excluding the EK Redesign)
- Local Care including primary care **£211m**
- Mental Health - **£31m**

Health problems dog "red wall" areas

There are major health problems in the majority of the 48 parliamentary seats won from Labour by the Tories in December's general election. Figures from the Health Foundation think tank show that average female healthy life expectancy in the new Tory seats is just 60.9 years.

This is lower than the healthy life expectancy in the areas Labour held (61.4), below the England average of 63.9 years, and over four years less than the 65 years of life expectancy in wealthier traditional Tory seats.

The Health Foundation expresses the hope that the new cohort of northern and midlands Tory MPs will see this as "an incentive to take action on improving healthy life expectancy".

However for many older people it's already too late. The Health Foundation also points out that the strongest influences on health are "the circumstances in which we are born, grow, live, work and age," known as social determinants of health.

Poorest areas

The reality is that the newly-elected Tories now represent some of the poorest parts of the country, while the core of their party is based in the wealthiest: and only policies that seek to redistribute some if that wealth away from the richest can improve the living standards and living conditions of those on the lowest incomes.

Geographer Danny Dorling points out that after a decade of austerity and massive cuts in local government and welfare spending, life expectancy across the whole of the UK has begun to fall, for the first time in recent history: we are the only country in Europe where this is happening.

Tory ministers and Public Health England have tried to blame the weather and the flu – but the UK has not had an exceptionally cold winter since 2010, and there has not been a major flu epidemic.

Dorling points out that premature deaths of older people have risen as social care has been cut back, leaving a million without support, and real terms NHS funding has fallen.

But infant mortality has also been rising in England and Wales, but falling in Scotland, where the government has diverted funds to invest in mothers and babies.

NHS policies claim to be reducing inequalities in health, but there is growing concern that welfare and social care spending cuts are causing inequalities to widen, and a new report from the Nuffield Trust points out that this also applies to health care, resulting in a "double deficit", where people in these areas have greater needs but also poorer access to GP services and hospital care.

With a staggering £100 billion (and more) now being thrown at the dubious HS2 project to speed the journeys of wealthy people travelling north (and back again), many of those who voted Tory for the first time would benefit far more from dropping the planned new round of spending cuts, and instead spending even a fraction of the HS2 budget to improve health and social care and revive the flagging economy of what is becoming the 'northern poorhouse'.

Thank you – but we still need more support

A huge thank you to the supporter who has kindly donated a magnificent £5,000 towards this year's appeal to keep *The Lowdown* running without a pay wall and free to access for campaigners and union activists.

We have therefore always planned to fund the publication through donations from supporting organisations and individuals.

Having managed to raise enough money for our first year we now urgently need more to keep going.

We urge union branches to send us a donation … but also please propose to your regional and national committees that they invite one of our editors to speak about the project and appeal for wider support.

We know many readers are willing to make a contribution, but have not yet done so.

We are now asking those who can to give as much as you can afford.

We suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can give us more, please do.

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

● **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, as promised, we:

- established a regular one-stop summary of key health and social care news and policy
- produced articles highlighting the strengths of the NHS as a model and its achievements
- maintained a consistent, evidence-based critique of all forms of privatisation
- published analysis of health policies and strategies, including the NHS Long Term Plan
- written explainer articles to promote wider understanding
- created a website that gives free access to the main content for all those wanting the facts
- pursued special investigations into key issues of concern, including those flagged up by supporters
- connected our content with campaigns and action, both locally and nationally.

To go into a second year we need YOUR HELP

The Lowdown launched in February 2019 with our first pilot issue and a searchable website. Our initial funding came from substantial donations from trade unions and a generous individual.

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – **something that was not previously available to NHS supporters.**

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.

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

The aim of the project has been to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

To get it under way, we have worked hard to get the name established, build a core readership, and raise money where we can.

We need to make the project self-sustaining, so we can pay new journalists to specialise, and undertake investigations and research that other organisations aren't able to take on.


THE lowdown

Health news, analysis and campaigns. NUMBER 18, February 14 2020

Informing, alerting and empowering NHS staff and campaigners

Inquiry into chronic system failures at East Kent Trust

Repeated early warnings of problems had been ignored, including a damning report by the Royal College of Obstetricians and Gynaecologists back in 2015

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OPINION: Doctors for NHS chair COLIN HUTCHINSON in our new guest column Back

CHECK LIST or WISH LIST? NHS England's push for ICSs pages 8-11

NAO warns of "seriously unstable" NHS finances 10-11

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

We have had some success, and thank those individuals and organisations who have donated.

But seven months on, we need to step up our efforts to raise enough money to take us unto and through a second year, enough for us to be able to reach out and offer work to freelance journalists and, designers.

This autumn we will be making a fresh appeal to trade union branches, regions and national bodies – but also to individual readers.

We are providing this information free to all -- but it is far from free to produce.

If you want up to date information, backed up by hard evidence, that helps campaign in defence of the NHS and strengthens the hand of union negotiators, please help us fund it.

We urge those who can do to send us a one-off donation or take out a standing order.

More details of this and suggested contributions are in the box below.

Our commitment is to do all we can to ensure this new resource remains freely available to campaigners and activists.

Without your support this will not be possible.

NAO audit of NHS finances brands them "Seriously unstable"

The day after the government signed into law a settlement in cash for the NHS of £33.9 billion over the next five years, the government's own auditors the National Audit Office (NAO), warned that years of underinvestment has led to parts of the NHS being "seriously financially unstable" and that some are building up levels of debt which they are never going to be able to repay.

Added to this are warnings from the NAO that the state of the NHS's infrastructure, some of which is older than the NHS itself, is a danger to patients due to a lack of maintenance.

NHS provider trusts reported a combined deficit of £827 million and clinical commissioning groups (CCGs) a £150 million deficit in the financial year ending 31 March 2019, according to the NAO.

The auditors noted that any extra money from the government to stabilise the finances of individual NHS bodies had not been fully effective.

Trusts in financial difficulty had increasingly turned to short-term loans from the Department of Health and Social Care to get through. The trusts treat these loans as income, and by March 2019 trusts had built up debts totalling £10.9 billion. The NAO notes: "there is no realistic prospect of this debt being repaid."

No room for efficiency savings

What is also clear, according to the NAO, is that trusts are finding it much harder to make efficiency savings and are becoming dependent on short-term measures to meet financial targets.

In 2018-19, 31% of their savings were one-off, up from 26% in 2017-18. Relying on one-off savings means that trusts must find new savings each year in addition to savings already planned.

Equipment levels, such as MRI scanners, are way lower than in other European countries

Raids on capital budget

The financial stability of the trusts is linked closely with the dire situation with NHS infrastructure - hospitals, clinics and equipment, all of which suffer from a lack of maintenance.

The budget for these things - the capital budget - has been repeatedly raided by the government; from 2014/15 to 2018/19 the government took £4.3 billion from the capital budget to fund day-to-day running costs of the NHS.

Equipment levels, such as MRI scanners, are way lower than in other European countries, and 14% of the NHS estate pre-dates the NHS (1948) and is totally inadequate for modern healthcare services.

The government also does not know what impact these repeated transfers in budget has had on patients' services, note the NAO, but with the bill for backlog maintenance standing at around £6.5 billion, and high-risk maintenance at £1.1 billion, up 139% from 2014/15 to 2018/19, the NAO conclude that there is an increased risk of harm to patients.

Repeated funding calls

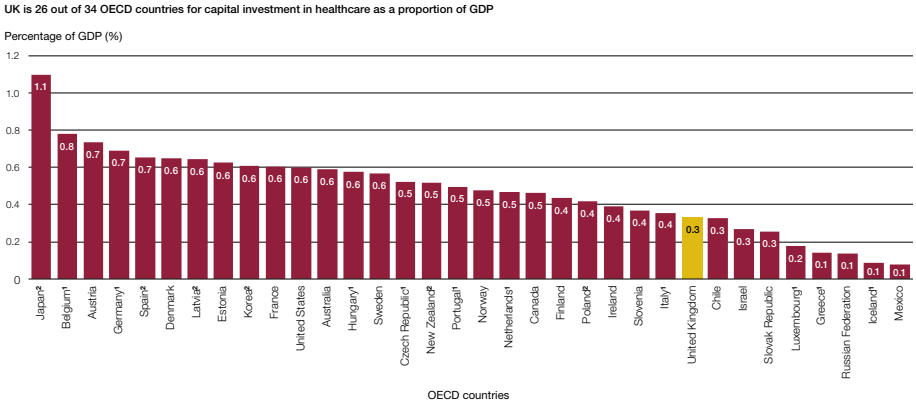
The NHS trusts have asked for more money for capital costs - over the last three years, NHS providers have requested on average £1.1 billion per year more for buildings and equipment than their spending limits allow.

The government's approach to infrastructure spending has been piecemeal. Last year the government's promise was £2.7 billion to rebuild six existing hospitals and a pledge to build 40 in total and upgrade 20 others.

The NAO's conclusions, however, are that there is a real need to move away from such piecemeal funding promises

Figure 11

Capital investment in healthcare as a percentage of gross domestic product (GDP), 2015 or nearest year (Organisation for Economic Co-operation and Development (OECD))



Notes

1 Refers to gross fixed capital formation in International Standard Industrial Classification (ISIC) 86: Human health activities (ISIC Rev. 4).

2 Refers to gross fixed capital formation in ISIC Q: Human health and social work activities (ISIC Rev. 4).

3 Gross fixed capital formation is defined as "resident producers' acquisitions, less disposals, of fixed assets during a given period plus certain additions to the value of non-produced assets realised by the productive activity of producer or institutional units. Fixed assets are produced assets used in production for more than one year" (European System of Accounts 2010).

Source: Organisation for Economic Co-operation and Development (OECD) Health Statistics 2017, OECD National Accounts

and that DHSC, NHS England and NHS Improvement should develop a clear long-term capital funding strategy and establish a more stable funding system that is not reliant on loans.

Commenting on the reports, Anita Charlesworth, director of research and economics at the Health Foundation, said:

"The NAO has sounded a timely warning bell about the significant financial and operational challenges facing the NHS.

"Even with the government's proposed investment, the health service will struggle to maintain current levels of patient care in the face of growing demand, let alone deliver the ambitious improvements to services promised by the NHS Long Term Plan."

New strategy

A change in approach in funding is also called for by NHS Providers, the organisation which represents the 240 NHS trusts. Its report - Rebuilding the NHS - calls on the government for major investment and changes to the way capital projects are funded.

It asks the government to make investments in infrastructure akin to the national building programme in the 1960s and the investment that took place between 1999-2010; this level of investment could amount to around 100 new hospitals.

The report also calls for capital funding to "at least double" from the current £7.1 billion, and to draw up a 10-year capital investment plan so trusts can plan ahead and modernise ageing infrastructure.

The current government promises are "a much more modest ambition than what was achieved under previous initiatives", according to NHS Providers, and "the recent capital announcements, though welcome, also fall well short of what is needed."

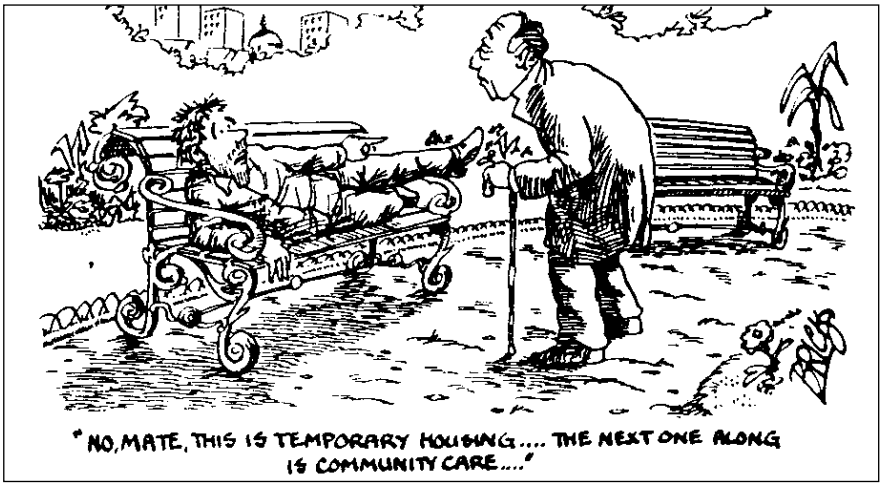
The report from NHS Providers also emphasises the need for capital funding for mental health, community and ambulance services as well as the acute hospital sector.

Holes in the budget

The widely reported budget settlement for NHS England, praised by government ministers, covers day-to-day running of NHS services, but the wider health budget which provides funds to modernise hospitals, train doctors and nurses, and run prevention services has not been given the uplift it needs.

These other parts of the NHS have had to rely on unpredictable handouts or add-ons, which mean trusts can not plan adequately.

'The NAO highlights that the NHS did not fully achieve the vision set out in the previous major plan for the NHS. Without substantial, long-term funding commitments to public health, workforce education and training, and capital, the NHS risks ending up in the same situation again.'



Councils short-changed on social care

This week the government gave the final confirmation of an additional £1.5bn for social care in 2020-21. However, council leaders were disappointed at the government failure to include any additional money to cover the late December announcement of a 6.2% increase in national minimum wage and living wage.

Councils were hoping that some additional money would be forthcoming to help them cover the wage increases. In a statement the Local Government Authority (LGA) said:

"We are disappointed that the government has not used the final settlement to provide the £220 million needed to pay for the faster than expected rise in the National Living Wage (NLW) from April..... this unforeseen new cost pressure needs to be funded to avoid the fragile care provider market being further destabilised."

Although the government touted the funding settlement at 4.4%, as the largest increase in a decade, the LGA noted that the settlement is only for one year and in order to improve services, rather than "just keep them running", a long-term funding settlement is necessary.

Furthermore, no public health settlement has yet been published, which makes it extremely difficult to plan proper services. Social care and public health are intertwined with the NHS and vital in reducing the strain on the NHS.

£1 billion of the new funding comes from the government, with the remaining £500 million being raised by local authorities from council tax rates and increasing the tax precept that provides dedicated funding for adult social care services by a further 2%.

"Crunch time" message to PM

Care England, the organisation representing companies that provide social care, has said that it is "crunch time" for the industry and has urged the Prime Minister to act on his pledge to tackle the social care crisis within 100 days of the election.

Care England's CEO, Professor Martin Green OBE, said:

"The incumbent Government has until 22 March to act upon the Prime Minister's pledge to tackle social care within 100 days of his election. The stabilisation of the adult social care sector should be the Government's first priority, inaction is no longer viable."

"The stabilisation of the adult social care sector should be the Government's first priority"

The Conservative election manifesto in December 2019 contained little on social care, just a vague plan to "build a cross-party consensus on long-term social care funding".

This followed several years of promises for a green paper on social care, but no action.

Theresa May promised a green paper in the March 2017 Budget; this followed the decision in July 2015 to defer proposals put forward by the "Dilnot Commission" and accepted in principle by the then Coalition Government.

The 2017 general election campaign included a manifesto commitment to introduce a social care Green Paper and also made a number of pledges regarding how individuals pay for their social care.

Trade unions celebrate a year of successes

It is UNION week, and it's been a busy year for Trade union members as they face the reality of a health and care system under pressure. Despite working harder than ever staff face tough threats to their pay and conditions, but they have been fighting back and with some success.

Just this week drug and alcohol support workers in Wigan announced plans to strike after their employer, Addaction refused to keep pace with NHS rates for equivalent jobs.

Staff who were transferred to the London-based charity from Wigan Council voted unanimously to take industrial action, echoing a string of similar disputes across the health and care sector.

Fair Pay and patient safety

In December and January 26,000 staff from Northern Ireland made history by striking for better pay and increased staffing, in a healthcare service currently beset by crisis.

The action coordinated by Unison, RCN and Unite brought mass media attention to crucial safety issues and won an improved deal from the government.

While the unions viewed the deal as "not perfect" it delivered an extra £60m for staffing, including an additional 900 nursing trainees and over time there will be a reduction in the reliance on agency staff

UNISON General Secretary Dave Prentis said: "Our members in Northern Ireland have not only achieved pay parity against great odds, they have won the support and respect of the people of Northern Ireland by their determination to stand up for the rights of patients and health workers alike.

Compass

Throughout October hospital cleaners, caterers, porters, receptionists and security workers went on strike over the company's failure to match health service pay rates and working conditions.

Most of the Compass employees are on the minimum wage (£8.21 an hour), yet work alongside colleagues employed directly by the NHS, where the lowest hourly rate is £9.03.

This difference of 82p an hour is worth around £1,500 a year for full-time staff, according to Unison. who levelled criticism at the company for disciplining staff that had spoken out.

In Doncaster and Bassetlaw joint action by Unison and GMB members over two days resulted in the staff being offered a pay deal matching the NHS pay scales and backdated.

Strikes in Northern Ireland were backed for the first time ever by the RCN and supported by lively pickets

Security staff in Southampton

Last year security staff at Southampton General Hospital were frequently being attacked in the A&E department by members of the public either under the influence of drink or drugs, or with mental health problems.

Their employer, Mitie was criticised for not supplying protective equipment, and employees were angry at the level of financial support offered to those who had been injured in the attacks. A two day strike led to further discussions involving officials from Unite over a new package for the employees.

Unite lead officer for health in the south east Scott Kemp said: "Unite is pleased to announce that our security staff at Southampton General Hospital have accepted a package that includes increased pay rates, improved sick pay arrangements, and new PPE equipment."

Sodexo

Back in April/May 2019, catering staff at Doncaster and Bassetlaw NHS Foundation Trust voted to take strike action over their pay conditions. After their services were privatised back in 2017, they were assured they would remain on NHS pay scales.

However the French company, Sodexo, said that pay could not be matched, "As part of the 2018 Agenda for Change pay deal, the Department of Health agreed to centrally fund new pay rates for NHS employees in England.

"However, this funding has not been extended to include those employed by private contractors, such as Sodexo.

Joint action by Unison and GMB members over two days resulted in the staff being offered a pay deal matching the NHS pay scales and backdated.

Back in-house

A thousand low-paid porters, cleaners and catering staff at Imperial College Healthcare NHS Trust in London will transfer back into the NHS, after Sodexo hands back the service contract that they have run since 2015.

As part of the transfer back to the NHS, staff from Sodexo will see their pay, overtime, pensions and sickness allowances brought in line with other health service workers, ending years of unfair treatment.

Hospitals managed by the trust include: Charing Cross, Hammersmith, St Mary's, Queen Charlotte's and Chelsea, Western Eye.

Lincolnshire health visitors

A month long strike by 70 health visitors employed by Lincolnshire County council was paused after the council agreed to the majority of the affected staff being moved up the pay scale, saving the

Bradford support staff defeated plans for a WOS

worst affected from losing £4000 a year.

Unite regional officer Steve Syson said: "Thanks to the tremendous solidarity that our members have shown since this dispute started in the summer, we have achieved a highly significant and welcome victory."

Wholly owned subsidaries

Across the country cash-strapped hospital trusts have announced proposals to develop private companies to employ non-clinical staff, taking advantage of VAT rules.

Over the last two years as plans have come forward they have been consistently challenged, and some successfully halted, in campaigns run by unions, healthcare staff and activists.

After three weeks of action and lengthy negotiations between Unison and the Trust Board, senior executives at Bradford NHS Trust agreed to drop plans to transfer porters, cleaners, security staff and others into a private company.

Eleventh hour agreement between unions and bosses at Frimley Health Foundation Trust avoided planned strike action and the planned transfer of 1000 staff to a wholly owned subsidiary - Unison, Unite and the GMB had been coordinating events including a human chain around the hospital to highlight the issue.

Privatisation

In May 2019 The High Court ruled against Circle's appeal to continue running Nottingham Treatment centre, a contract they were first awarded back in 2008, rewarding campaigners and trade unions for their joint efforts to oppose the privatisation which was reportedly earning Circle an annual profit of £2.9 million.

Circle lost this legal action against Rushcliffe CCG, leaving Nottingham University Hospital free to begin the five-year contract to run Nottingham Treatment Centre. Circle felt this decision was "flawed" and "unfair"

Get involved, share your stories and encourage people you know to join a union – more information on Union Week 2020 ***HERE.***

Lincolnshire health visitors notched up a victory

Residential care dragged down by private equity

With those involved in social care hoping for some long-term funding for the social care system in the upcoming budget on 11 March, there is another crisis bubbling slowly in the residential care sector - the precarious financial state of many of the largest private companies involved in the sector.

These companies entered the market over the last three decades to take on residential care that had previously been provided by councils. The sector seemed to be a safe bet for good returns due to the guaranteed income stream from councils and an ageing population.

But then austerity led to dwindling council resources and cuts to council budgets and suddenly the income wasn't quite as good, despite the companies charging ever inflated fees.

Private equity takeover

Since the 1980s global private equity, sovereign wealth funds and hedge funds have seen the residential care sector as a source of steady income. Hundreds of care homes passed into the control of companies with a focus on short-term investment. These companies, such as HC-One, Four Seasons and Care UK, have complex structures, including off-shore funds.

The companies have been lumbered with vast amounts of debt as the companies were sold and then restructured.

A prime example is Four Seasons, once owned by the Guernsey-based company Terra Firma, and now, due to being unable to pay its debts, owned by its largest creditor, the Connecticut-based hedge fund H/2 Capital Partners.

According to a recent Financial Times article Four Seasons "consists of 200 companies arranged in 12 layers in at least five jurisdictions, including several offshore territories." Despite the difficulties tracking the company's finances, the FT notes that it is clear that the company is laden with debt - around £1.2bn of interest-bearing debt and loans from unspecified "related" parties.

High levels of debt and the company heading for insolvency, did not deter the directors of Four Seasons from taking substantial salaries from the company; the FT reports that in 2016 the directors' pay totalled £2.71m, of which the highest paid received £1.58m and in 2017 five company directors shared £2.04m, and the highest paid received £833,000.

The behaviour of these companies has been highlighted before, the CHPI reported in November 2019 in Plugging the Leaks in the Care Home Industry, on the staggering amount of money paid out to directors, on loan repayments, and rent.

The report notes that £261m of the annual income received by the largest 26 care home providers goes towards paying off their debts, and £117mn (45%) of this are payments to related, and often offshore, companies.

If the government eventually comes up with a workable solution to the crisis in care, it's clear that some form of tighter regulation is needed for companies who run these homes.

At present the Care Quality Commission has few regulatory powers over these companies - all it can do is warn local authorities if companies are on the brink of bankruptcy to give the local authorities time to find new providers so that vulnerable people are protected.

The CHPI report recommends full disclosure of income, regulation to prevent companies with certain financial set-ups providing care in the UK, and greater involvement from the government with capital provision for new care homes.

According to the FT article, it is even now clear to people involved in the sector that more regulation is needed.

Jon Moulton, who ran Four Seasons in the early 2000s, told the FT "that regulators should be taking stiffer action, requiring care home chains to hold a certain amount of capital, much like the Financial Conduct Authority requires of banks."

Checklist or wish list?

NHS England Guidelines tighten reins on ICSs

John Lister

NHS England has now published an exhausting list of requirements for local provider trusts, CCGs and embryonic "Integrated Care Systems," (ICSs) setting them on a route march to a bizarre form of "integration".

The NHS England vision for integrated care is that the NHS be split into three main levels: neighbourhood (30,000-50,000 population), "place" (250,000-500,000) and "system" (1 million to 3 million), with NHS England and NHS Improvement controlling the whole set-up at regional and national level.

To do this they need to effectively disregard (or persuade government to change) the existing legislation – forced through by the Tory-LibDem coalition in the Health and Social Care Act 2012 – which carved England's NHS up into a market consisting of local commissioners (200+ CCGs) holding the purse strings, and providers (NHS Trusts, Foundation trusts and GPs, private – for-profit and non-profit – and voluntary sector.)

The 2012 legislation abolished the previous wider local structures (100+ Primary Care Trusts) and regional bodies (Strategic Health Authorities): now NHS England is seeking to put together a new version – so without any statutory powers or legal standing, and without any accountability or transparency at local level.

They are driving the mergers of CCGs, with 56 set to disappear in a new round of mergers from April, leaving just 135 (with more mergers planned), and reorganisation of services into 42 Sustainability and Transformation Partnership (STP) areas, which according to NHS Improvement's chief operation officer are expected to develop into ICSs by April 2021.

The NHS Operation planning and Contracting Guidance 2020/21 is the latest step towards establishing NHS England's plan: it is only 40 pages long, but densely packed, with each page studded with extra demands on local health bosses.

The common factor running through all the demands on local commissioners and providers is NHS England's determination to force them into "Integrated Care Systems" – despite the absence of any legal powers or legitimacy for such bodies to be established, and therefore little if any public accountability for their actions.

No public involvement

There is no mention of public involvement, engagement – or indeed of the public at all, except as the recipients of services commissioned and decided by local health systems. Instead the Introduction claims that the NHS has since last year been in a period of "stability" with the limits of its funding now set in law up to 2024:

"The NHS and its partners have used this stability to develop local system-wide strategic plans during 2019 that will put the NHS on a sustainable financial footing whilst expanding and improving the services and care it provides patients and the public."

This same blinkered approach – ignoring manifest and major problems – means NHS England makes no reference to the changes they want made to the law, which were outlined in the Long Term Plan and spelled out in more detail during last year.

The Guidance gives no indication of any concern at the lack of commitment of the Johnson government to honour its manifesto pledge to pass the necessary legislation to give ICSs legal standing, and to lift the current legal requirement on CCGs to carve local services into a series of contracts to be put out to competitive tender.

NHS England is forging ahead as if they already had their preferred version of a more centralised system in place

It now seems, according to carefully leaked rumours headlined in the Times, Telegraph, Daily Mail and Independent, that the legislation when passed will include new powers for ministers (and of course Johnson's Downing Street Svengali Dominic Cummings) to give orders to NHS England's boss, the freshly-knighted Simon Stevens.

The *Times* reports concerns of health chiefs who fear this could amount to a fresh reorganisation of the NHS. Campaigners will fear it will assert centralised control while not fully repealing the 2012 Health and Social Care Act that entrenched a costly and divisive "market" in health care.

The Planning Guidance indicates NHS England is forging ahead as if they already had their preferred version of a more centralised system in place, and spells out ways in which commissioners and providers in 42 STP areas are increasingly required to work together as a single "system".

Section 2.1 of the Guidance makes clear that ALL systems are expected to agree five separate arrangements with NHS England's regional directors which are key to them progressing to ICSs:

- **a leadership model for the system,** "including a Sustainability and Transformation Partnership (STP)/ ICS leader with sufficient capacity"….
- **system capabilities** "including population health management, service redesign, workforce transformation, and digitisation" ….
- **agreed ways of working** across the system in respect of "financial governance and collaboration" …
- **streamlining commissioning** arrangements, "including typically one CCG per system"
- **capital and estates plans** at a system level… .

Front line staff face a tough assault course of targets: "waiting lists should be lower"

These are to ensure ICSs can carry out two "core roles": system transformation and collective management of system performance (pulling individual trusts into line).

System planning

Section 2.2 of the Guidance is on "system planning", again focused on ensuring that every commissioner and provider each of the 42 systems is tied in with "local strategic plans" (few of which have yet been published). In other words the plan is to override the existing (limited) local accountability and existing statutory responsibilities of trusts and CCGs.

Section 3 sets out a tough assault course of performance targets which systems are expected to achieve. In Primary Care a tokenistic carrot of £45m of development funding is to be shared between 42 systems, while the stick includes requirements to invest in extra staff (the unfortunately named ARRS scheme (Additional Roles Reimbursement Scheme), extra doctors, delivering reductions in long waits for routine appointments, and "full delivery of online consultation systems" (whether patients want them or not).

Just £45m of development funding is to be shared between 42 systems

Community health services, with little if any extra resource are required to work to deliver "crisis response services within two hours of referral, and reablement care within two days of referral to those patients who are judged to need it" – although no details are published on how far away they are from that target, or where they are supposed to find staff and funding.

On mental health (3.2) the Guidance refers to (but does not reproduce) over a dozen rigorous "deliverables" to improve performance, despite the fact that the 135 CCGs that will exist from April have to share out a measly £135m "Long Term Plan baseline funding to bolster community mental health provision," and will get back only 40% of the salary costs of the additional trainees they will need to expand IAPT services.

On learning disabilities (3.3) along with a series of vague commitments to "ensure there is the right range of support and care services in the community", and to "increased use of Personal Health Budgets", there is a requirement to visit adult inpatients in out of

Continued page 10

Tightening the financial screws

The Guidance sets out new financial controls, with the imposition of "system control totals" that attempt to force collective responsibility for achieving these targets. This is a challenge for what have until now been relatively loose and vague agreements.

Last month the HSJ questioned the extent to which ICSs really are integrated or committed to common control totals, noting:

"to date only Dorset ICS has gambled all of its sustainability funding [SF] on meeting the collective control total. All other systems, even those that have been accepted as fully fledged ICS such as Surrey Heartlands and Bedfordshire, Luton and Milton Keynes, have resisted pooling all their SF — keeping much of it linked only to individual providers' financial targets."

It appears from the more detailed Section 5 on finances that NHS England has tacitly conceded the difficulty of this: what happens, for example if some trusts in an STP/ICS area sign up for a system control total (spending cap), but others won't? How will rivalries between big trusts in local systems be dealt with?

The political price of forcing major cuts or a closure of a trust is

"I'm not Dr Jekyll – I'm Mr Hyde the accountant"

such that NHS England has limited scope for financially squeezing those with the biggest problems.

So while the release of revenue transformation funding will depend on NHS England/Improvement approval of system plans, only ***half*** of the Financial Recovery Fund is to be tied to the financial performance of the whole system, and trusts may still get a proportion of their FRF even if they don't meet the targets.

However 50% of a trust's allocation will be based on its own performance (p30). Where they do not deliver "financial trajectories," any FRF money that has been "paid but not earnt" will be converted to additional debt ("DHSC financing").

To make matters worse (p30), organisations that miss their financial targets "will not automatically be entitled to the system element of their FRF allocation" – effectively imposing an additional penalty for being under-funded.

There are also reward payments for providers that break even or achieve a surplus in 2019/20 and 2020/21: so for the minority of relatively affluent trusts and FTs the system is very rewarding, while the others must dodge their way through penalties and mounting problems.

Section 5 on Finance (p37) also makes clear that NHS England is still tightening down on trusts and CCGs which have continued to provide and pay for treatments which are deemed to be of low clinical value: trusts will be given targets for reducing provision, and this will be further enforced by the CQC:

"Proposed activity reduction numbers by CCG, provider and ICS/STP will be provided. We will ask systems to develop their own plans with a view to meeting or exceeding these numbers. The system plans will need to be agreed with all providers and commissioners. … Performance against the Evidence-Based Interventions programme is being incorporated into CQC reviews for providers of NHS services." (p37)

Checklist or wish list?

(from page 9)

area placements every 8 weeks, and children every 6 weeks – hardly inspiring for those fearful these patients will be largely neglected and forgotten.

On urgent and emergency care (3.4) there is a historic shift away from three decades of efforts to reduce front line bed numbers:

"systems and organisations will be expected to reduce general and acute bed occupancy levels to a maximum of 92%. This means that the long period of reducing the number of beds across the NHS should not be expected to continue. …

"The default operational assumption is that the peak of open bed capacity achieved through the winter of 2019/20 will be at least maintained through 2020/21, including the 3,000 increase from October 2019 already planned for."

Credible plans

It appears that the onus is now on those seeking to reduce bed numbers, or increase by a lower amount, to produce "Credible plans to release capacity through reductions in length of stay, improvements in Delayed Transfers of Care (DTOCs), and admission avoidance programmes". But we have heard similar before from NHS England, without any let-up in the run-down of bed numbers.

Despite recent warnings on lack of capacity from the Royal College of Emergency Medicine and the Society of Acute Medicine, there is an ambitious target to increase "same day emergency care" by September, and 65% delivering acute frailty services.

And as trusts implement plans to institutionalise it, with corridor nurses and paramedics, NHS England is demanding measures to avoid ambulance delays and "eliminate corridor care".

"the long period of reducing the number of beds across the NHS should not be expected to continue"

"Waiting lists should be lower"

More ambitious still are the demands on elective care (3.5): "Specifically, the waiting list on 31 January 2021 should be lower than that at 31 January 2020. …

"Providers should ensure appropriate planning and profiling of elective and non-elective activity throughout the year, taking into consideration expected peaks in non-elective performance over winter months in order to avoid risk of unplanned cancellations.

"Waits of 52 weeks or more for treatment should be eradicated."

So easy to say, so hard to do without sufficient beds, staff, capital or revenue. Indeed if it was that easy it would already have been done.

Similarly fanciful demands follow for changes to outpatient services (3.6), reduced waits for cancer treatment (3.7), and an even more unrealistic section on public health (3.8), which simply piles on more tasks and targets without giving any baseline figures on the current state of play, discussing the cuts in funding that have been made, or identifying any additional resources.

The "People" plan (Section 4) continues the theme of wishful thinking, though it does note that the infamous promise of 50,000 extra nurses is to be delivered "by 2025," (together with 6,000 more

Dis-integrating NHS care

John Lister

While NHS England works to tighten the strings that bind so called Integrated Care Systems to central control and regional NHSE bureaucracy, the DIS-integration of local services continues with the contracting out of more services … driven by NHS England itself.

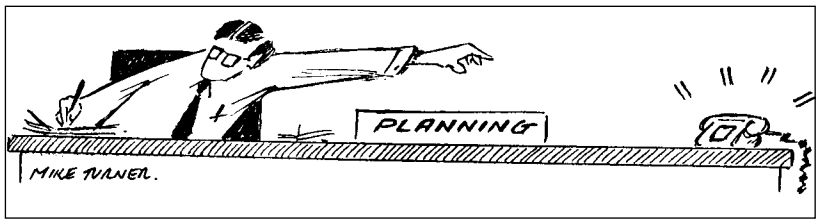
The Lowdown has reported the various moves towards privatisation in the new pathology and imaging networks that are included in the Long Term Plan.

NHS England has also set up a list of accredited companies plus a few NHS providers to offer trusts and CCGs a range of services that can "support the move to integrated models of care based on intelligence-led population health management".

The services on offer are:

- Enterprise-wide Electronic Patient Records Systems – for Acute & Community and for Mental Health Hospitals
- Local health and care record strategy and implementation support and infrastructure
- ICT infrastructure support and strategic ICT services
- Informatics, analytics, digital tools to support system planning, assurance and evaluation
- Informatics, analytics, digital tools to support care coordination, risk stratification and decision support
- Transformation and change support
- Patient empowerment and activation
- Demand management and capacity planning support
- System assurance support
- Medicines optimisation

Of the 83 accredited suppliers for these services,



The growth of SBS is a reminder of the commitment of the Tory government to the fragment-ation of the NHS

76 are private companies, almost a third of them (23) US-based. Only 7 are NHS organisations.

Among the big American corporations are McKinsey, Optum, a branch of the giant UnitedHealth (former employers of NHS England boss Simon Stevens) IBM, Centene, Cerner, Deloitte and GE Healthcare.

McKinsey has been influential in the NHS for decades, and Optum has already won contracts for a range of data-based services for the ICS programme.

Provisional wing

But while these no doubt profitable (but questionably useful, see box) services are confined to the back offices of trusts and CCGs, just before Christmas NHS England's provisional privatisation wing, Shared Business Services, widened the net.

They now include clinical care, inviting providers, including NHS, non-profit and for-profit companies, to apply to be included in a 'Framework agreement' for the supply of outsourced clinical services, including Cardiology, gynaecology, paediatric and oncology services.

This is intended to make it easy for trusts to award contracts for various services.

NHS SBS invites in various private and other

doctors working in primary care and a 26,000 increase in the wider primary care workforce).

The credibility of the proposals is not enhanced by the focus on "a significant expansion of ethical international recruitment of high-quality nurses, driven by a new national programme which will be established early in 2020."

Government erecting barriers

It appears nobody in NHS England has noticed the government's efforts to deter immigration of anyone earning less than £30,000 a year, and the associated hefty upfront costs of even the discounted NHS visa and the commitment to jack up the annual "Immigration Health Surcharge" to £625 per year.

But then the Planning Guidance appears to be more of a wish list than a check list, not so much blue skies thinking as cloud cuckoo land. Only the strings and financial penalties are real – and the extent to which these can make trusts and commissioners jump through NHS England's hoops remains to be seen.

Whether any of this can meaningfully be called "integration" is another question.

The test is in the financial discipline. While the HSJ has reported the "unprecedented" decision of the merging CCGs in Norfolk and Waveney to chip in with financial support "to help two acute trusts agree control totals", The Lowdown waits with interest to see the first trust or foundation trust running a surplus that is willing to part with some or all of it in order to ensure a local system including trusts in deficit can meet its control total.

providers into networks of approved outsourced suppliers, from whom trusts can buy in services without themselves going through a full process of competitive tendering - by simply choosing a supplier from the list (or conducting a 'mini-competition' between a few already authorised suppliers).

In other words it is batch privatisation, aimed at encouraging NHS trusts to outsource services (with the lure of varying possible "discounts") – or "insource" them, by bringing contractors into Trust premises to deliver services – rather than providing them themselves (and paying staff on NHS terms and conditions.)

Contracting out

This could in some cases mean contracting out whole units or services (and presumably transferring existing trust staff, or making them redundant).

This is at present on a relatively small scale (£117m over 2 years for clinical services, compared with an NHS England budget of around £115 billion) but clearly the aim is for this to be the start of something bigger.

Because SBS conducts all of this procurement and sets up the "framework" of privatisation centrally, allowing trusts to make OJEU-compliant appointments from its lists of 800+ "approved suppliers", it also ensures there will be even less chance of any local public discussion or consultation of the outsourcing, which might otherwise take place if decisions are made through the Trust boards, which meet in public.

The continued growth of NHS Shared Business Services and its eager promotion of private providers is a further reminder of the commitment of the Tory government to the fragmentation of the NHS and salami slicing profitable contracts for the private sector under the banner of "integration" -- while the taxpayer foots the bill, and the NHS takes the blame for the gaps and failures in an under-funded system.

No evidence to back key NHS England policy

New research in the USA has exposed the lack of evidence that costly and complex data-led attempts at "population health management," and targeting the small number of patients with complex medical and social needs (so-called "super-utilisers") who account for a large proportion of health care costs, can either reduce demand or cut costs.

A study in the New England Journal of Medicine revealed that the US "Camden model" (using a multidisciplinary team of clinicians, social workers, community health workers, and health coaches to work with patients in the hospital and then at home, with a primary goal of helping patients stay out of the hospital) had no impact on hospitalisations or associated costs in a 6-month follow-up period:

Summarising the latest findings in the Millbank Quarterly, Paula Lantz, who has analysed dozens of similar reports argues that while these "much-anticipated findings" have been described in the press and on social media as "surprising," "shocking," and "disappointing,"

"The unfortunate reality is that these evaluation results are not surprising at all. Red flags regarding the hype and overpromise of super-utilizer interventions have been waving for several years. …

"The majority of super-utilizers live in communities facing multiple socioeconomic challenges. They also have been exposed to decades of constrained opportunities, social/environmental risks, and chronic psychosocial stress, much of which stems from institutionalized discrimination and structural deprivation. We should not be surprised that the social determinants of health create high-need/high-cost patients who do not experience sudden improvements 6-12 months after a case management intervention. …

"The truth is that hot-spotting interventions are primarily cost-containment strategies aimed at individual, very expensive patients. They are not interventions aimed at the macro- and community-level systems and institutions that drive social, political, and economic disadvantage and health inequities."

Similar findings in England have also been ignored for the past seven years by NHS England, who are throwing good money after bad on ill-conceived, privately-led and costly data-driven systems at the core of ICSs, all of which we can already predict will fail to deliver the promised results.

This is a new feature in *The Lowdown*, in which we invite observers and campaigners to air their own views on an NHS-related topic of their choice

A question of trust

Colin Hutchinson, Chair, Doctors for the NHS

One of the most controversial elements of the despised Health and Social Care Act 2012 was the establishment of NHS England as an "arm's length body", or quango, as they used to be known.

The NHS Act 1946 set out the duty of the Minister of Health to provide, or secure the provision of, the services required for a comprehensive health service in England and Wales.

The Conservative-Liberal Government's 2012 Act changed this fundamentally, to a duty to promote a comprehensive health service. At a stroke, this removed much of the ministerial accountability for the way in which services were to be delivered – "It's not me guv: blame the doctors in the Clinical Commissioning Groups, or the bureaucrats of NHSE/NHSI/HEE!"

Power grab

The Times of 8th February ("No 10 in NHS power grab"), reported that the Government is developing legislation that would fundamentally reform the 2012 Act, rather than the more limited workarounds that Simon Stevens wanted to enable the formation of Integrated / Accountable Care Organisations.

The Prime Minister apparently wants to make sure that NHSE is "appropriately accountable to the Secretary of State and Parliament" and that ministers have "sufficient levers to direct and influence NHSE". Bye bye arms' length!

Calls to stop the NHS being a political football are not new, but a service that has such a profound part to play in the life of almost every person in the country, and which needs so much funding from the public purse, cannot be anything other than a political issue.

The competence and financial commitment of the government of the day should be open to public judgment at the ballot box. What is vital, however, is for the planning of the service to be based on a much longer timescale than the five year electoral cycle.

This is not just the case with the NHS: a similarly long view needs to be taken in the response to climate change.

Commanded and controlled

Campaigners realise that bodies that were meant to offer opportunities for the public to influence local decisions - NHS Trusts, CCGs and Health and Wellbeing Boards - are nothing of the sort. They are commanded and controlled by NHSE.

That chain of command is currently strengthened by merging CCGs, aiming for one CCG per Integrated Care System.

Accountability for local services becomes increasingly remote and the ever greater involvement of commercial organisations in the planning, administration and delivery of health services means that Freedom of Information requests can be refused on grounds of "commercial sensitivity".

Bodies that were meant to offer opportunities for the public to influence local decisions … are commanded and controlled by NHS England

Things aren't great at the moment, but are they about to get worse?

Is the Government intending to take power away from NHSE, but leave accountability with the quangos – so that the Government can pull the strings while avoiding blame when the wheels fall off?

Is there a wish to strengthen the disastrous experiment in offering up the NHS to market forces and commercialisation, and convergence with the US system?

Is this move simply another facet of the turf war which has just led to the resignation of the Chancellor?

It would be lovely to believe that this Government has finally realised the folly of the pro-market policies pursued by successive governments over the past thirty years, resulting in:

- destabilisation and fragmentation of clinical services that take many years to build up;
- wilful neglect of the need to train sufficient doctors, nurses and allied health professionals, to deliver universal healthcare in every community in the country;
- the demoralisation of the existing workforce, by denying them the resources needed to deliver care to the appropriate professional standard;
- the siphoning of huge amounts of public money that should be supporting frontline services, into the pockets of middlemen and corporations whose primary aim is to extract the greatest profit possible;
- patients falling through the gaps resulting from organisations working within the limits of responsibility set out in their contracts.

Lovely

It would be lovely to believe that this Government has recognised that universal healthcare is a highly cost-effective investment in the people of this country.

It would be lovely to believe that this Government is planning legislation based on the NHS Reinstatement Bill, removing the profit motive from the NHS and harnessing the power of public service, which previously served this country well.

It would be lovely, but …