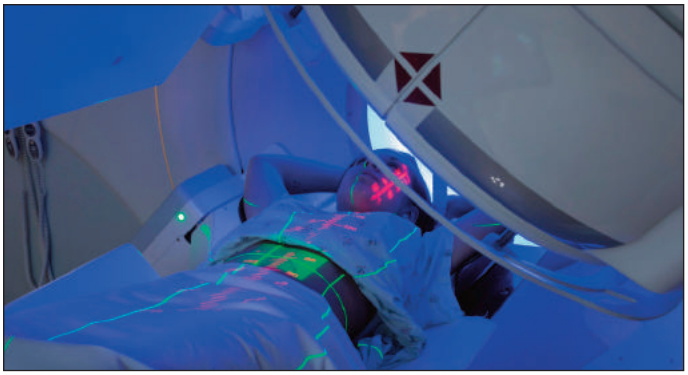
The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

# Nottingham rations cancer care for lack of staff



**More than a decade of frozen funding has brought the NHS to a shocking new stage of crisis, in which cancer treatment in one of the country's leading hospitals last month had to be rationed for lack of staff, with some patient denied continuing care. Patients are having to be selected for treatment on the basis of how likely they are to survive and recover, meaning that palliative care is being cut back.**

Nottingham University Hospitals NHS Trust said they "expect to be in a position to restart chemotherapy for all patients who require it in October." But while the Trust has admitted to the problem, the state of affairs was only initially revealed in a blog by cancer specialist Lucy Gossage, who says:

"Right now we don't have the staffing capacity to deliver chemotherapy to all our patients and so, for the first time, the prioritisation list has come into force. And that means that, currently, we are unable to offer chemotherapy that aims to prolong life or palliate symptoms for many people with advanced cancer. We hope this is very temporary, but it's indicative of a system on its last legs…"

The Nottingham restrictions are in line with contingency plans drawn up in March 2020 as the pandemic was growing to its peak, but come at a time when waiting lists are growing and the focus is on reducing the level of pent-up and delayed demand for cancer treatment.

Last month an IPPR report Building back cancer services in England warned that up to 20,000 cancer diagnoses could have been missed during the pandemic.

In the year following the first lockdown, 369,000 (15%) fewer people than expected were referred to a specialist with suspected cancer. There was a 13% drop in radiotherapy treatments, and 7% fewer chemotherapy sessions. There were also fewer diagnostic tests: 37% fewer endoscopies, 25% fewer MRI scans and a 10% drop in CT scans between March 2020 and February 2021.

The result is that even if the level of services is cranked up by 5% per year it could take until 2033 to get waiting times back to pre-pandemic levels, because of increased demographic pressures on service demand.

However if activity could be increased and maintained at 15% higher than 2019 levels: "most backlogs across the cancer care pathway could be addressed by next year. That would prevent many cancer-related deaths. Achieving this relies first and foremost on a larger workforce, more diagnostic and treatment equipment, and more physical space to provide care."

All of this requires funding, and a commitment to increase training to expand the specialist workforce. The Royal College of Radiologists in its appeal for extra funding from the coming Comprehensive Spending Review, points to the dire shortage of key specialists ("the NHS radiologist workforce is now short-staffed by 33% and needs at least another

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## *Also in this issue...*

# Patients in poorer areas wait longer for treatment

**Areas of deprivation in England have seen waiting lists on average increase by more than half (55.2%), compared to a third (36%) in the least deprived areas, according to research by the think-tank The King's Fund, with the national average increase at 42%.**

As well as having higher waiting lists, patients are also likely to have to wait longer on the lists in areas of deprivation. Although the number waiting more than one year for treatment has increased across England, the King's Fund analysis showed that 7.29% of those in deprived areas had been waiting longer than a year, compared to 4.02% in the least deprived areas. This means that on average you are 1.8 times more likely to experience a wait of more than one year if you live in one of the most deprived areas.

Commenting on the analysis, Saffron Cordery, Deputy Chief Executive of NHS Providers, noted how important support from central government and local health systems will be to work through the backlog in a way that is tailored to meet the needs and tackle the inequalities within the communities they serve.

"It is deeply worrying that according to this analysis patients in deprived areas are nearly twice as likely to wait a year or more for planned treatment. Trusts are working flat out to maintain and restore services, while keeping people safe and preventing the spread of COVID-19. It is vital that in addressing the care backlog, due emphasis is given to deal with disparities in access and outcomes for disadvantaged people living in the most deprived areas."

The government set up the Elective Recovery Fund (ERF) in March 2021 specifically to help NHS organisations (trusts and integrated care systems) to cope with the waiting lists. However, the ability of organisations to reduce these waiting lists was dealt a serious blow in July 2021 when NHS England and NHS Improvement made changes to the ERF, which means many organisations are not being paid at the level needed to tackle backlogs..

In March 2021, the thresholds of activity that ICS had to meet to earn money from the ERF was set at 85% of 2019/20 activity, but in July 2021 just three months into the financial year, the NHSE changed the rules to a threshold level of 95% of 2019-20 activity levels.

Now HSJ reports that NHS organisations have lost out on millions of pounds to help them tackle backlogs. HSJ has seen declarations from multiple local NHS organisations confirming they will get either no income or substantially less than expected from the national elective recovery fund.

HSJ reported that when the threshold changes were announced, ICS leaders told it there would be a "financial impact" and accused NHSE of "not just [moving] the goalposts" but "[taking] the entire pitch".

HSJ reports that South Yorkshire and Bassetlaw ICS, will lose planned income of around £22m, North Cumbria Integrated Care Foundation Trust expects to incur losses of £2m between July and September due to the threshold change, and County Durham CCG said it was missing out on funding after being granted £1.2m for April and May. These are probably just the tip of the iceberg.

***Sylvia Davidson***

***...continued from page 1***

1,939 consultants to keep up with pre-COVID-19 levels of demand for scans"), funding and equipment:

"Any equipment that is more than ten years old can be considered obsolete or inadequate for conducting certain procedures and must be replaced; yet previous industry surveys have shown one in ten CT scanners and nearly a third of MRI scanners in UK hospitals exceed this threshold and hence pose a risk to patients.

"The UK also has fewer scanners than the majority of comparable OECD countries - 9.5 CT scanners per million population while France has 18.2 and Germany has 35.1."

NHS England argues that in June and July this year, more than 50,000 patients started treatment for cancer, an increase of one third compared to the reduced level of treatment in the same period last year. However despite a few brave words from NHS England last week there is little sign of progress on the roll-out of Community Diagnostic Hubs promised by NHS England a year ago, or the £1bn network of surgical hubs called for by the Royal College of Surgeons as a way to focus resources on reducing waiting lists.

***John Lister***

# Fuel problems impacting on care of ill and vulnerable

**The BMA, the Queen's Nursing Institute, the Royal College of Nursing, the Homecare Association, which represents home care workers, healthcare unions, teaching unions, the mayor of London, Sadiq Khan, and many many other organisations that work with vulnerable people and in essential services have all urged the government to prioritise essential workers - NHS staff, carers, teachers - at petrol stations.**

Soon after the panic buying of petrol began, so did the reports of essential workers having trouble finding fuel meaning they were unable to get to work on time or at all. The queues have resulted in community nurses and carers being late for appointments and in rural areas they are having to make decisions about who they can visit.

Dr Crystal Oldman, chief executive for the Queen's Nursing Institute, which represents community nurses, wrote to Boris Johnson on 28 September, warning that vulnerable people are already being affected: "Shortages in the supply of fuel are already impacting on care to ill and vulnerable people at home and in care homes. Patient visits are being cancelled and patients are at risk of being left without the care they need, at the time they need it. This is unacceptable."

On Tuesday 28 September ITV reporter Paul Brand joined a carer as she tried to find fuel so that she could visit her vulnerable clients. A long wait for petrol meant she was late for her first visit of the day, a client who could not get up without the carer's help and consequently had to lie in a wet bed for some time.

The Guardian reported on the same day that some appointments for cancer patients at University College hospital (UCLH), one of London's largest hospitals, have had to be rescheduled due to the fuel shortage.

The spokesperson said: "Owing to the national fuel supply we are rearranging a small number of outpatient appointments over the next few days for patients who are due to be brought into our hospitals by our non-emergency patient transport provider, offering virtual appointments where possible."


### Calling up reserves

Both Prime Minister Boris Johnson and the UK BUsiness Secretary, Kwasi Kwarteng, have resisted the calls to designate priority pumps and have been insisting that the situation is improving. But by midday 29 September, Kwasi Kwarteng, said that the government's reserve tanker fleet will be on the road Wednesday afternoon to boost deliveries of fuel.

The trucks are reported to be driven by civilians and number 80, according to a 2019 assessment. The business secretary also said that 150 soldiers were being trained to drive fuel tankers in the coming days.

The panic buying of fuel was triggered by reports from BP that it was having to close some of its petrol stations due to a shortage of HGV tanker drivers. The shortage of HGV drivers is primarily due to Brexit - the end of the transition period in early 2021 when the UK left the EU single market meant hauliers were then prevented from recruiting drivers in the EU.

Saturday 25 September saw the government offer temporary three month visas to 5,000 foreign drivers. Comments from EU drivers in the media and on social media, however, imply that there won't be a rush to apply for these visas. There is plenty of work across the EU for HGV drivers, where facilities are far better and there is no need for visas.

***Sylvia Davidson***

# Consultants claim Royal Sussex hospital is 'extremely unsafe'


**Consultants working at Brighton's Royal Sussex County Hospital (RSCH) – the major trauma tertiary centre for the South East coast – have written to their chief executive warning that the site is currently "extremely unsafe" for patients, and have suggested that all elective activity should temporarily be diverted elsewhere.**

In the letter, sent last week to University Hospitals Sussex (UHS) Foundation Trust chief executive Dame Marianne Griffiths, and seen by the BBC and online news site HSJ, surgeons and anaesthetists working at RSCH claimed that operating theatre staff levels were "dangerously low", and referred to a "downward spiral of losing many experienced staff" because of low morale and pandemic-related burnout. The consultants also highlighted the "dysfunctional, uncaring and incompetent" record of the hospital's management.

The move came as acute hospital trusts across England continue to experience very high levels of bed occupancy, and UHS itself highlighted the associated safety concerns by publicising the World Health Organisation's 'Patient Safety Day' on its Twitter feed just days before Dame Griffiths received the consultants' letter. Earlier this summer more than a third of general acute trusts were operating at levels exceeding NHS England guidance – set at a maximum of 92 per cent – with eight trusts nearing 100 per cent in May.

That same month UHS refused to reveal the full findings of an independent review of its neurosurgery department, conducted by the Royal College of Surgeons in 2019, and opted instead to release a heavily redacted report which excluded the number of incidents resulting in either 'moderate' or 'severe' harm. UHS medical director Dr Rob Haigh told the BBC at the time that the full report could not be released simply because it "contains confidential information".

Looking back over the past decade, it certainly seems the controversy surrounding last week's consultants' letter stems from problems that have been brewing for a decade.

In March 2013, for example, nurses working in A&E at RSCH told the BBC they felt unable to deliver good patient care because of overcrowding and understaffing, and a month later HSJ found that BSUH – the body which then managed both RSCH and the Princess Royal Hospital in Haywards Heath – had the highest number of patients in England waiting more than 12 hours to be admitted to A&E.

In June that year the CQC told RSCH to improve because of concerns over lack of washing facilities and overcrowding in its A&E department, and it had to repeat the message 18 months later when the commission again found that the hospital's A&E required improvement, this time along with RSCH's maternity services.

The problems continued, however, and in October 2015 inspectors from the CQC were obliged to formally rate the safety and management of RSCH's A&E unit as 'inadequate', and they raised particular safety concerns. And the following year the commission told BSUH to make significant improvements to RSCH – citing patients being put at unnecessary risk because they were not being dealt with properly – and subsequently put the trust into special measures after inspectors still found it to be unsafe and poorly led.

But in January 2019 it looked like the tide was turning, when BSUH was given a clean bill of health by the CQC, and rated 'good' overall and 'outstanding' for caring, following an inspection in September 2018, the same year that the trust emerged from financial special measures.

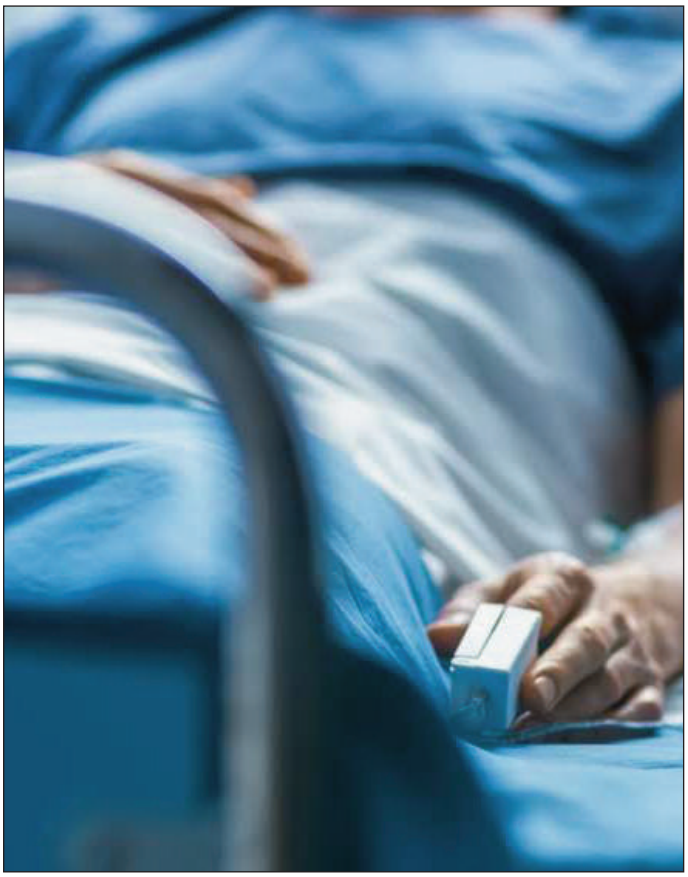
### Change on the way

And BSUH's subsequent merger, earlier this year, with the Western Sussex Hospitals NHS Foundation Trust – the first non-specialist acute trust in England to be rated 'outstanding' in all the key inspection areas assessed by the CQC – to form UHS was expected to result in further improvements to the performance of RSCH, alongside those many hope will also stem from the near-£500m, helipad-equipped revamp of the hospital's Victorian-era infrastructure.

That revamp is scheduled to see the completion of a new 'urgent treatment centre' next spring, augmenting RSCH's A&E capability, but it remains to be seen whether any of these admittedly positive developments materially impact on the issues raised so forcefully in the hospital consultants' letter to Dame Griffiths last week.

***Martin Shelley***

# NHS capacity – room for improvement?



**New guidelines from the UK Health Security Agency (UKHSA) – one of the bodies taking over from Public Health England – recommend halving from 2 metres to 1 metre the "physical distancing" to be maintained in healthcare facilities to protect against transmission of the Covid-19 virus.**

The new proposals do not apply to emergency departments where patient access and movement is harder to control, but have been read as meaning that NHS hospital beds can be moved closer together – restoring some of the capacity that was lost in 2020 as the pandemic set in.

The UKHSA guidance, which also removes the need for a negative PCR and 3 days self-isolation before selected elective procedures, and allows NHS providers to revert to standard rather than enhanced cleaning of buildings leaves decisions on how to implement this new regime to local management.

However it's not at all clear that the new 1 metre distancing rule is intended to apply to hospital beds, or even practical to apply, since the gaps between beds were larger than this even before the pandemic.

In June 2020 NHS Providers, warning that greater distancing between beds would inevitably reduce the numbers of beds in use, stated that the normal average space between beds was 1.6 metres in older buildings and 1.8m in newer hospitals.

This is a significant reduction from the 2000 guidelines for the building of University College Hospital London, which allowed 2.7 metres between beds, while subsequent increased space was recommended in Hospital Building Notes based on ergonomic studies which established that "most activities carried out at the bedside could be accommodated within the dimensions 3.6m (width) × 3.7m (depth)."

The minimum size of these gaps is dictated among other things by the need for access for cleaning staff and, when necessary, for monitors, drips and emergency equipment, as well as ensuring visitors to one patient do not impinge on the space for neighbouring patients.

### Screening off the problem

Some hospitals during the peak of the pandemic were unable to space out the beds to the full 2m, and resorted to hanging clear flexible screens to provide a physical barrier between bed spaces to provide additional protection.

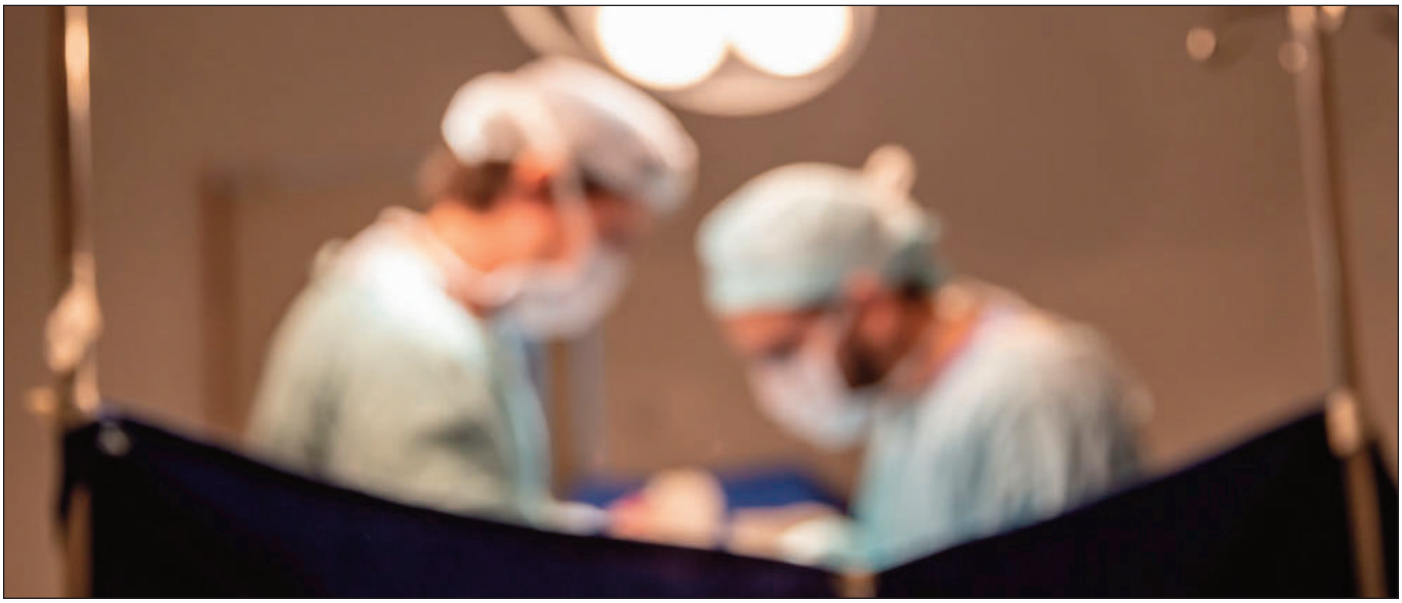
In July 2020 NHS England's director of estates discussed the need to commandeer some of the spaces allocated to offices and non-clinical services in order to maximise the area available for beds with enhanced distancing.

But with backlog maintenance bills for NHS trusts totalling £9 billion at last count and rising rapidly, and plans for the 40 or 48 new hospitals likely to be scaled back to fit the constrained availability of capital for any kind of investment, it's clear there has been a lack of funds for the reorganisation needed to get bed numbers and capacity back to anything like pre-Covid levels.

At the end of September 4916 beds in England were filled with Covid patients, acting as a further limit on capacity to treat the normal caseload. The latest bed availability and occupancy figures (up to end of June 2021) show a loss of 4,567 front line general and acute beds since the equivalent quarter pre-Covid – and a much bigger drop in numbers of beds occupied – down by almost 10% (8,906).

In January the HSJ concluded that up to half of the apparently "unoccupied" acute beds in hospitals were in fact not available for use by non-Covid patients – in addition to the beds closed as a result of the pandemic. There's a very long way to go before the NHS comes anywhere near to restoring the capacity it had prior to Covid-19.

***John Lister***



# Thousands 'go private', many more forced to wait

**Since the pandemic began early last year, NHS waiting lists – currently sitting at 5.6m, and growing by 150,000 a month, up by 20 per cent since the start of the pandemic and predicted by health secretary Sajid Javid to eventually hit 13m – are now a prime consideration in private health companies' business model, and as the lists grow, so do those companies' profits, driven by rising numbers of patients effectively forced to use their services.**

And even those patients who can't afford private surgery – in the latest Healthwatch England poll, that's almost 50 per cent of respondents waiting for delayed treatment – often have to pay just to manage their pain levels.

Research by charity Versus Arthritis, revealed in a recent BBC Panorama documentary, found that 54 per cent of people with arthritis and currently waiting for surgery spend on average more than £1,700 a year on private physiotherapy and over-the-counter painkillers.

No wonder then that a survey of 4,000 adults by charity Engage Britain last month found that 21 per cent – that's more than one in five – had had to go private because NHS treatment was unavailable, and another survey earlier this year showed that 13 per cent of consumers in the UK already belonged to a private medical insurance scheme, and more than half – 53 per cent – said they would pay for private treatment.

No wonder too that leading UK provider Spire Healthcare last month reported a pre-tax profit of £4.7m, against a loss of £231m a year earlier. It claimed it had made no profit from the government's bulk-purchase arrangement last year – of which it was one of the main beneficiaries – despite making £486m from its NHS work. Spire reported record revenues from private patients without health insurance paying for their own treatments, with the number up almost 47 per cent from pre-pandemic levels. The increase helped lift the company's revenues nearly 40 per cent to £558m.

Suspicions that the pandemic was leading to the creation of a two-tier health system began to surface 12 months ago. According to one newspaper report, Compare the Market recorded a 40 per cent increase in private health insurance sales over the preceding seven months – ie since the first lockdown began in 2020 – and HCA Healthcare admitted that self-pay surgeries and procedures in some areas had doubled over the same period.

### Milking the demand

Spire Healthcare also reported a similar surge in commercial activity last year, while health data company Laing Buisson – which in April this year estimated the value of the self-pay market at £1.1bn a year, and reported that the market was expected to grow by 10-15 per cent over the next three years – claimed that smaller operators were also milking the pent-up demand stemming from NHS waiting lists by offering procedures to those without insurance who were prepared to pay.

Centre for Health and the Public Interest (CHPI) director David Rowland told the Guardian last month that private opera-

tors were already trying to create a new type of health consumer who pays for their own treatment before the pandemic, and were seeking to make self-pay more attractive by offering fixed-price packages with some hospital groups, such as Nuffield Health, even offering zero-interest finance. Chillingly, he noted that lucrative cancer treatments became the biggest single earner for private hospitals in London in 2019.

In fact the sheer volume of non-urgent elective work continuing to be performed in the private sector at the beginning of this year, while the health service still remained under pressure, led to a joint letter from regional medical directors urging their counterparts in London not to support staff who were also working outside the NHS, for a limited period. As both the CHPI and the Health Foundation thinktank have noted, surgeons and other senior clinicians are rarely if ever employed directly by private hospitals, but are mostly NHS doctors.

HealthInvestor UK magazine MD Vernon Baxter also told the Guardian last month, "The pandemic will have a long-lasting impact on the self-pay market. With the NHS under pressure for the foreseeable future, the concept of paying out of pocket to expedite treatment will be increasingly commonplace – for those who can afford it."

**Two-tier system on the way?**

CHPI director David Rowland expressed similar concerns to the newspaper: "There is a big risk that unless government provides adequate funding for the NHS, more and more people will be forced to pay privately, which in turn will undermine middle-class support for a tax-funded NHS." He predicted the possibility of ending up with a two-tier system, where the NHS is a residual service for those without the means to pay.

But mining a handy new income stream as patients stuck on NHS waiting lists reluctantly go private has only added to the gains made by the private sector since the pandemic began.

A national block-purchasing 'cost price' contract, negotiated in the first few weeks of the lockdown in 2020 and designed to augment NHS capacity, saw the private sector's capacity – the bulk of it offered by Spire Healthcare and Circle Health, and representing just 8,000 beds – put at the disposal of the health service during the pandemic.

This was thought to have cost the NHS around £400m a month – more than £1.5bn in total, although the exact figures have not so far been published – and at the time was seen by some as a rescue package for commercial interests experiencing a rapid drop in patients (and hence income), rather than a genuine attempt to ease pressure on the health service at a time of national crisis.

Concerns were also expressed that companies owned by Conservative Party donors, or those with previous connections to the Department of Health & Social Care, benefited from a block-purchasing deal which proved of questionable value to the public purse.

Documents leaked to online news site HSJ last December suggested that two thirds of this capacity went unused, despite NHS waiting lists lengthening by the day. And earlier this year the CHPI revealed that the 26 private contractors involved in the block-purchase deal rarely treated more than 65 patients on any given day, and that on some occasions no private beds were being used at all for covid patients.

**Staffing a core issue**

A subsequent procurement framework, introduced in November 2020, replaced the block-purchase set-up with a longer-term plan, but this entails NHS England paying private hospitals up to £10bn over the next four years – instead of investing that cash directly into the health service – in order to help reduce its waiting lists.

This ongoing generosity by the government to the private sector offers a strong contrast to its approach to funding the NHS. Headline-grabbing announcements of £36bn being made available over three years to clear the backlog fail to address longer-term structural and staffing issues within the health service.

A new report from the Health Foundation, released at the beginning of October, found that the NHS and social care in England will need more than 1.1m extra staff over the next decade to keep up with growing demand, because of the ageing population and greater numbers of patients with long-term illnesses, as well as the backlog caused by the pandemic. The NHS in England currently has 94,000 vacancies, including for 9,691 doctors and 38,952 nurses, and the Health Foundation estimates the cost of bringing the public sector capacity back up to full strength at £86.4bn, more than double the £36bn that is now on offer from the government.

The BBC Panorama documentary mentioned earlier rightly focused on the growing health inequalities faced by many patients in the UK, denied urgent care but unable to leapfrog waiting lists and pay to go private. It highlighted one case where a family had had to resort to crowdfunding to pay for a teenager's scoliosis operation in Turkey before his condition became inoperable.

The NHS was set up in 1948 to combat exactly this sort of inequality – where patients and their families in effect have to beg to pay for their healthcare – and the need to restore the health service to its former status has never been more urgent. Particularly, as one commentator has warned, with private operators now deciding whether to position themselves as a partner to the NHS, or as a competitor. .

***Martin Shelley***


# Exploring flaws in the Health and Care Bill

**As the Health and Care Bill proceeds through the Committee stage, belated critiques and assessments have begun to appear flagging up serious questions over the effectiveness of the emerging system of Integrated Care Systems (ICSs).**

### CPS report

One traditionally right wing think tank, the Centre for Policy Studies (which boasts on its website that it was "founded in 1974 by Sir Keith Joseph and Margaret Thatcher and was responsible for developing the bulk of the policy agenda that became known as Thatcherism") has published a report questioning the evidence that "integrated care" can deliver any improvement in outcomes for patients.

Perhaps this is not such a great surprise, since the Health and Care Bill proposes to establish 42 statutory ICSs by scrapping one of the core sections (Section 75) of Andrew Lansley's hugely controversial Health and Social Care Act, which followed in the tradition of Thatcherism by entrenching competition and a competitive market in the NHS.

However the CPS report does appear as disenchanted with the Lansley reforms as it is with the latest government attempts to unpick them. Its author, Karl Williams, notes that the latest changes, as with almost every previous reorganisation of the NHS, appear to have been embraced uncritically by all and sundry:

"the alarming truth is that, as with the Lansley reforms, this seismic reform of how the NHS works has had surprisingly little

scrutiny. To put it bluntly, everyone is in such fervent agreement that the ICS model of integration and collaboration is the future of the NHS that hardly anyone appears to have looked properly at whether this approach works in practice."

Williams points out that four years ago the National Audit Office warned of the lack of evidence to show integrated care could deliver the promised improvements in patient care – and that there still is vanishingly little evidence – if any – to prove it can.

Perhaps surprisingly given its ideological approach, the report draws on some serious and evidence-based research into the performance since 2016 of the 13 early implementers of the ICS model, with a particular focus on two of the largest – Greater Manchester and West Yorkshire and Harrogate. 2016 was when the notion of "integration" was first systematically raised by Sustainability and Transformation Plans, which have since morphed into ICSs.

Williams focuses on Delayed Transfers of Care (DtoCs), numbers of which patients medically fit enough to be moved from acute hospital bed to a care home or to their own home with sufficient support remain marooned in hospital. This is one of the areas where "integrated care" between the NHS and social care is supposed to improve performance, but the figures suggest otherwise: "DtoCs across England as a whole were 14% higher in 2016-2020 than in 2012-2016. However, in in STP/ICS areas, the increase was 24% (when weighted for population).

"In other words, across the 13 early movers, delayed transfers of care (DtoC) increased by 70% more than the national average, resulting in over 80,000 extra hospital bed-days across a four-year period."

In fact the figures show an above England average increase in seven of the 13 early ICS areas, ranging from a 17% increase in Suffolk and NE Essex to a massive 111% increase in Gloucestershire, with Greater Manchester on 65%, while six were below England average, with West Yorkshire showing no increase and Nottingham & Nottinghamshire achieving a 7% reduction.

On each of the measures different areas appear at the top and bottom of the comparisons, suggesting that there is no coherent pattern of success or failure. West Yorkshire and Greater Manchester are both found to have four "firm failures," in the comparison of outcomes, but only one shared failure – the reduced percentage of the workforce with clinical qualifications. Greater Manchester also shows failures on DtoCs, respiratory disease mortality, neonatal outcomes, while West Yorkshire's problems are with emergency readmissions, mental health and admissions linked to alcohol.

Only on levels of attendance at A&E do most ICSs show an overall improvement on the England average, although even here five ICSs are worse than average, the weakest being Dorset.

Williams sums up: "… the evidence above does not suggest that the ICS model has been a disaster. But it definitely shows that it is not a panacea: in particular ICS status appears far less significant in determining healthcare outcomes than other factors, including how well or how badly the trusts in question are managed." (page 78)

He goes on to warn that ICS structures face the danger of becoming bureaucratised, that accountability mechanisms are "poorly defined," that ICBs "could actually cement the dominance of secondary care," and as we might expect from a Thatcherite think tank, raises fears that:

"While the purchaser/provider split in the NHS is being kept in theory, in practice it looks likely to be greatly diluted."

More significantly he also warns of the likely cost of establishing ICSs:

"Even semi-effective implementation of the ICS reforms in their current form is likely to be costly. The GMHSCP received a one-off sum of £450m (equating to 7.5% of the region's annual health and social care budget) to help in its transformation into an ICS …. If each of the 29 ICSs established since the first two ICS waves were to receive similar funding, the Government would need to find about £7 billion."

Williams' major recommendation is to drop the Health and Care Bill's proposed legislation to establish ICSs on a statutory basis, and hold back on such action, allowing the 13 ICS pilot schemes to run for FIVE YEARS … "until around 2026":

"If outcomes data for the 13 ICSs unexpectedly show significant improvement, then the newer 29 ICSs can accelerate down this path of integration, using best practices tested and refined by the pioneers."

**DHSC assessment**

Meanwhile a very different approach can be seen in the Department for Health and Social Care's 54-page Impact Assessment of "Core Measures" in the Bill, which effectively brushes aside any potential costs, and makes no reference to the levels of additional funding which Williams assumes to be required to establish ICSs.

It does admit that "there is mixed evidence on whether collaboration can provide cost savings in the delivery of services," but claims there is consensus that "collaboration between health and care organisations and the reduction of siloed working can and should go further." (p9)

The Impact Assessment (IA) is specifically only addressing the Bill's proposals linked to NHS England's Long Perm Plan. It timidly distances the government from the disasters of the 2012 Lansley reforms pushed through by the Tory-Lib Dem coalition, noting that while "The 2012 Act was designed in part to drive value by raising

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the importance of commissioning and competition in the system," subsequent experience showed that "improvements envisaged as flowing from this approach did not materialise to the extent that was hoped." (p8)

Noting that the Bill brings an end to the pretence of GP-led commissioning, the IA admits:

"… a NIHR research programme between 2014 and 2018 did not find clear evidence that the involvement of local clinicians in the commissioning of acute hospital services provides health benefits."

The IA goes on to stress the costs and delays that are involved in competitive tendering, making the case for the repeal of Section 75 of the 2012 Act, although two of the three scenarios discussing the likely situation under NHS England's proposed Provider Selection Regime assume that contracts would be awarded or rolled over without competition to a private provider. (p35-36)

The IA underlines the fact that the Bill does not prevent and could facilitate additional outsourcing and privatisation:

"Competitive tendering will allow decision making bodies to test the market when this provides an opportunity to add valu for patients, taxpayers, and population without generating adverse impacts …. This in turn will provide businesses with opportunities to enter the market and work alongside decision making bodies to contribute to these objectives." (p36)

**IPPR report**

A third major assessment of the Bill has come from the once left of centre IPPR ("The Progressive Policy Think Tank"), who have published a new report Solving the Puzzle - Delivering on the promise of Integration in Health and Care, by Parth Patel.

This report is also based on some potentially useful research, focusing on the inequalities between the 42 ICS areas, after working with management consultants Carnall Farrar to develop an "integrated care index" to enable comparisons to be made. But frustratingly it gives us only a few bullet point glimpses of the full findings.

It appears to show patterns of inequality that are as inconsistent as those found by the CPS report.

So for example there are almost nine times more delayed discharges per 1,000 bed days in Norfolk and Waveney ICS than there are in Sussex and East Surrey ICS. But conversely the rate of maternal deaths is 16 times higher in Sussex and East Surrey than in Suffolk and North East Essex.

People with severe or complicated mental health problems in Bath and Northeast Somerset, Swindon and Wiltshire ICS are three times more likely to have a care coordinator than those in Leicester, Leicestershire and Rutland ICS.

Children with a mental health emergency in Birmingham and Solihull ICS are 80 per cent more likely to be seen by a mental health specialist within four weeks compared to children in Gloucestershire ICS.

Patients in North London ICS are 81 per cent more likely to say they lack access to sufficient support from local health and care services compared to patients in Dorset ICS.

In typical IPPR style the report includes plenty of hypothetical situations:

"If the current reforms are successful, each ICS should show an improvement in our integrated care index. That will only happen if the government matches its reforms with a plan to provide ICSs with the resources and capabilities they need to deliver improvement." (p9)

But we already know from government funding announcements (and now from the Impact Assessment, which makes no reference to any increases in funding) that there will be no extra resources to match the reforms: so it's fair to conclude that the ICSs WILL FAIL to deliver the promised improvements, and the levels of inequality will remain at least the same or widen.

In equally pointless speculation Patel concludes that if all the new 42 regions matched the performance seen in the top 25 per cent it would mean 42,600 more bed days available in the NHS because of fewer delayed discharges. That's a pretty big "if".

However the IPPR report is not entirely without value. Under 'Building a Culture of Collaboration' it makes proposals that include "ICS members should have the power to democratically remove their chair." (p12)

It also proposes "Limiting legislative proposals to give the secretary of state greater powers of direction over NHS England and local service reconfigurations," (p15) and calls for "A 'Long Term Plan' to overhaul the quality of social care," (p15) arguing the obvious point that that "Better integration with the NHS will remain challenging without improving the employment conditions of care workers and without improving the quality of social care providers." And it proposes patients should be represented on each ICB. (p21)

Overall both IPPR and CPS reports underline concerns that the case for a complex top-down reform to impose "integrated care" is less than convincing, and that the legislation itself is contradictory in boosting central powers while apparently seeking to devolve more decision-making. Both reveal the need for extensive amendments to minimise the damage of a deeply flawed Bill.

Both reports emphasise that any positive change in patient outcomes is dependent upon more resources to address weaknesses – while the DHSC's Impact Assessment makes clear no such resources are coming.

***John Lister***

# Fewer mask-wearers test positive, says ONS


**Vaccinations and wearing a face mask in enclosed spaces reduces your chance of testing positive for Covid-19, according to recently released data from the Coronavirus Infection Survey (CIS) being conducted by the Office for National Statistics (ONS).**

This large survey of households across the UK has been tracking the presence of Covid-19 infection in the community since mid-April 2020. Participants are tested for Covid-19 infection using PCR and asked about how they live - their work life, behaviour, who they live with and come into contact with, and vaccine status. From the data it is possible to determine behaviour risk factors for infection - some of which people can not change, such as how many people they live with, but some that can be altered, such as mask-wearing. The success of vaccinations can also be tracked.

The most recent analysis for the fortnight ending 11 September 2021 also shows: people living in a household of three or more occupants were more likely to test positive; those in younger age groups were more likely to test positive; and those who reported socially distanced contact with 11 or more people aged 18 to 69 years outside their household were more likely to test positive for Covid-19.

The ONS survey continues to monitor Covid-19 in the community so the effect of vaccination of younger age groups will become evident over time. The use of masks, however, has fallen dramatically following the removal of any legal requirement to wear them.

Mask wearing is now down to personal choice, although retailers, public transport operators, and other industries can ask for them to be worn. The ONS survey indicates that those who choose not to wear a mask in enclosed spaces are about 50% more likely to test positive.

At the same time, the ONS also reported results from data collected for a longer time period, from 14 March 2021 to 11 September 2021, which showed that people who had one or two vaccine doses were less likely to test positive.

### Healthcare safer than hospitality

In addition, survey data collected from April to the end of August 2021 found that people working in healthcare were less likely to test positive for Covid-19 in six out of eight study periods (14-day blocks) between these dates, but people working in hospitality were more likely to test positive for Covid-19 in four out of five periods between 20 June and 28 August 2021.

The ONS is working with the University of Oxford, University of Manchester, Public Health England, Wellcome Trust, IQVIA and the Lighthouse laboratory at Glasgow to run the study, which was launched in mid-April 2020 as a pilot in England. The survey has since expanded and from 31 October 2020 reported headline figures for all four UK nations.

The survey began with swab tests, but many of the participants now also provide a blood sample for antibody analysis. This enables the survey to monitor the impact of vaccination on individual and community immunity and infection. Participants have been asked to stay on the study until April 2022.

Ultimately, the target for number of swab tests was approximately 150,000 individuals with swab test results at least every

*continued on page 13...*

# Back to the future as Javid appoints a General review

**It's back to the future once more, as recently-installed Health Secretary Sajid Javid succumbed to pressures from the Daily Telegraph, which has waged an ignorant campaign bemoaning the numbers of NHS staff who are not "clinically qualified" – and brought in a retired General to conduct a "review" of NHS management.**

The ill-founded belief in the powers of ex-military figures and former industrial bosses to "sort out" complex problems in the very different world of the NHS goes back to the mid 1980s, when the Thatcher government began to implement changes in the NHS management structure in line with the 1983 review of NHS management by Sainsbury's boss Roy Griffiths.

(Griffiths was later also to be the architect of the chaotic 1988 plans to split long term care from the NHS, and subject it to means tested and privatisation that has created the current chronic crisis in social care.)

In the late summer of 1984 the first appointments of district-level Griffiths-style "general managers" (soon to be re-styled – on higher pay – as chief executives) saw only 60% of posts retained by previous administrators, and some going to doctors or senior nurses, but the remainder handed over to (mainly) men and women from business and the armed forces. Most of the non-NHS appointees swiftly vanished without trace.

One of the first military men to take on the challenge was Colonel Peter Davis, who took over as general manager of Nottingham District Authority in early 1985, boasting that he brought a "new pair of eyes to see the wood from the trees and an empty mind to look and listen". He lasted just 18 months.

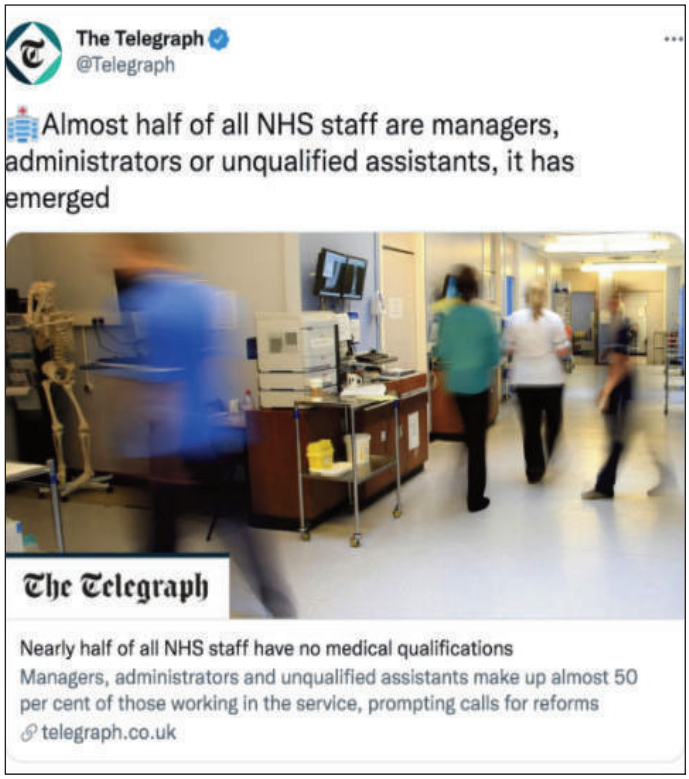
Also in and out quickly in South East London were Colonel Tony Hare, after a similarly truncated stint as General Manager in Bexley, and former RAF officer Peter Ward, who stayed even less time at his post in Bromley.

In January 1985, as the NHS scoured the world of Tory businessmen in the quest to recruit a £60,000 per year chair of the new NHS Management Board ministers were warned that:

"people of the calibre required were likely to be either too expensive and possibly too high profile, or affordable but reluctant to leave the private sector for fear of falling behind their peers."

As a result ministers wound up scraping a less promising barrel composed exclusively of second-raters "the unemployed, those who were not of the calibre required, or those nearing the end of their careers but who had not been successful enough to be out of reach financially."

They eventually opted for Victor Paige, a previous chair of the Port of London Authority, who admitted he had no Intention of cancelling his BUPA policy. "Like most people I am covered by private medical insurance," he blurted out. The director of personnel post went eventually to retired IBM executive Len Peach, who had almost no industrial relations experience. Neither lasted long.




### No confidence

In the autumn of 1989 Sir Derek Boorman, former Director of Military Operations in the Falklands War was appointed as chair of Camberwell District Health Authority, moving on in 1994 to chair the Royal Hospitals Trust spanning Barts and the London Hospitals, with a mission to close Barts – resulting in January 1995 in a motion of no confidence in him from 86 Barts consultants.

Boorman stayed on, to set up an extremely expensive inquiry into the leaking of a document, during the course which, according to Labour MP Brian Sedgmoor "there was an extraordinary homophobic outburst," in which Sir Derek made it clear that he regarded being gay as a human weakness.

Also involved with the attempted carve-up of Barts was Admiral Sir William Stavely, described in the Independent obituary as "one of the less approachable admirals," who "never courted popularity."

None of the military appointments have worked out well. There

has also been a chronic problem in seeking to bring in leadership from big business:

Nor is Sajid Javid's initiative the first Tory "war on bureaucracy" in the NHS. In 1995 his predecessor Stephen Dorrell tried a similar stunt, which wound up redesignating 4,000 managers as senior nurses, but leaving the system bureaucratised by Thatcher's "internal market" reforms virtually unchanged.

The Telegraph headlined the latest announcement as "Royal Marines general called in to bring military discipline to NHS management," claiming that he was "charged with driving up the quality of management and ensuring 'every penny' of taxpayers' money is 'well spent'."

The Guardian, however, reported NHS bosses criticising the review as a "slap in the face" after the pandemic, and arguing it is "a deliberate attempt to shift the blame for the health service's fragility," quoting one NHS chief stating: "It's hard not to interpret this as an attack. This will go down really badly, like a vat of cold sick."

One minor relief is that Gen Sir Gordon Messenger, a former vice-chief of the defence staff, is not being brought in as a manager or a chair of any NHS body, but purely to produce a report.

However the evidence from previous such reports is that they are either absolutely useless and swiftly discarded (as with New Labour's brief obsession of Professor, later Lord, Darzi's impractical and unaffordable proposals for "polyclinics") or really dangerous and the source of damaging changes (such as the 1983 and 1988 Griffiths reports, proposals for an NHS "internal market" by US guru Alain Enthoven, and the 2009 McKinsey report seeking up to £20bn savings from the NHS).

The chances are that the latest review (which will only focus on the NHS, not on the chaos in social care) will worsen the crisis, persuading even more hard-working NHS professionals and managers to seek the earliest possible retirement or change of career.

***John Lister***

***...continued from page 11***

fortnight from October 2020 onwards in England, approximately 9,000 in Wales, approximately 5,000 in Northern Ireland and approximately 15,000 in Scotland (approximately 179,000 total across the UK). The blood target is to achieve up to 125,000 people with blood test results every month in England, and up to 7,500, 5,500 and 12,000 per month in Wales, Northern Ireland and Scotland respectively (approximately 150,000 in total across the UK).

This analysis uses SARS-CoV-2 real-time reverse transcriptase polymerase chain reaction test (RT-PCR) results from nose and throat swabs of participants from the Office for National Statistics (ONS) Coronavirus (COVID-19) Infection Survey (CIS). The CIS is a large household survey monitoring current COVID-19 infections within the community population in the UK. Community in this instance refers to private residential households and it excludes those in hospitals, care homes and/or other institutional settings. Participants were asked about demographics, living environment, behaviours, work, and vaccination uptake. Further information on the study design can be found in COVID-19 Infection Survey: methods and further information.

**Relaxation of rules in the NHS**

The UK Health Security Agency – part of the Department of Health and Social Care – which has been created to advise on the pandemic and future threats, has recommended three changes to guidance.

The first is that physical distancing requirements be reduced from two metres to one metre in areas "where patient access can be controlled". This excludes emergency departments. It will allow some wards to house more beds, some having been removed early in the pandemic to prevent spread.

Secondly, testing requirements for elective surgery are set to be relaxed. Patients in low-risk groups who are fully vaccinated, have no covid symptoms and take a negative lateral flow test on the day of their procedure will no longer need to have a negative PCR test and isolate for three days beforehand. This requirement has made elective recovery more difficult.

Finally, standard cleaning procedures can be restarted in low-risk areas such as elective care, and "enhanced" cleaning — which involves more frequent cleansing of items that are regularly touched — can be discontinued in these areas, the UKHSA said.

**Comment**

There is no consideration given here to the services that sit around hospitals, and the effect that increased activity in hospitals will have (for example on step down and care facilities) - in particular, given the turnaround times for inpatients has decreased dramatically, with higher throughput, the services that support patients on their post-hospital recuperation are not ready (or in some cases restricted by temporary legislation that is yet to be relaxed - such as patient transport, where occupancy remains limited). The changes to hospital patient density need to be supported by the services that support before, and after these admissions, otherwise there will be excess bed days due to no ultimate discharge capacity, and regular safeguarding events.

***Sylvia Davidson***

# To help secure the future of our NHS through campaigning journalism, please support us

*Dear Reader*

Thank you for your support, we really appreciate it at such a difficult time. Before covid-19 the NHS was already under huge pressure, and after it's all over there will be a backlog of patients, queues of people affected by the crisis, and a hugely tired workforce.

From that moment we will need a much more credible plan to fund, support and protect our brilliant NHS. Our goal is to help make this happen and we need your help. We are researchers, journalists and campaigners and we launched The Lowdown to investigate policy decisions, challenge politicians and alert the public to what's happening to their NHS.

It is clear from the failures of recent years that we can't always rely on our leaders to take the right action or to be honest with us, so it is crucial to get to the truth and to get the public involved. If you can, please help us to investigate, publicise and campaign around the crucial issues that will decide the future of our NHS, by making a donation today. Our supporters have already helped us to research and expose:

- unsafe staffing levels across the country, the closure of NHS units and cuts in beds
- shocking disrepair in many hospitals and a social care system that needs urgent action, not yet more delays
- privatisation – we track contracts and collect evidence about failures of private companies running NHS services

First we must escape the covid-19 crisis and help our incredible NHS staff. We are helping by reporting the facts around the lack of protective equipment for hospital staff but also for thousands of carers. We are publishing evidence about more community testing and the shortcomings in our strategy to beat the virus. Even though they have a tough job, there have been crucial failings: on testing, PPE and strategy, and we must hold our politicians to account and challenge them to do better. We rely on your support to carry out our investigations and get to the evidence.

If you can, please make a regular donation, just a few pounds a month will help us keep working on behalf of the public and NHS staff - thank you. We all feel such huge gratitude and respect for the commitment of NHS staff and it's so impressive to see such strong public support. Let's hope that we can give the NHS the thanks it deserves and crucially, secure its future.

*With thanks and best wishes from the team at The Lowdown*

*EVERY DONATION COUNTS!*

We know many readers are willing to make a contribution, but have not yet done so. With many of the committees and meetings that might have voted us a donation now suspended because of the virus, we are now asking those who can to give as much as you can afford.

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

Supporters can choose how, and how often to receive information, and are welcome to share it far and wide.

You can donate here – or alternatively you can send your donation by BACS (54006610 / 60-83-01), or by cheque made out to NHS Support Federation and posted to us at Community Base, 113 Queens Road, Brighton BN1 3XG

If you have any other queries, or suggestions for stories we should be covering, please email us at contactus@lowdownnhs.info