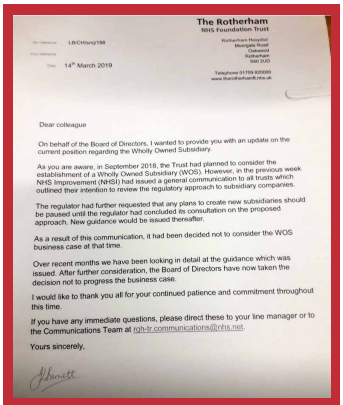
THE lowdown

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 colleague

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 rgh-tr.communications@nhs.net.

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.

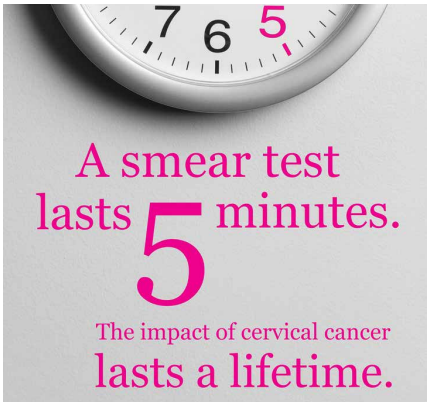
Since they took over the services, there has been a regular stream of reported problems. Issues with the cervical cancer screening programme are amongst the most recent to come to light.

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.

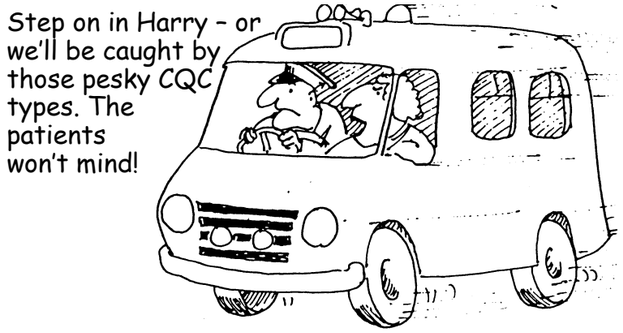
The level of private sector involvement in the ambulance service has been rising since 2012, with large contracts being advertised and awarded for non-emergency patient transport and more recently with emergency coverage included as well.

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.

STOLEN TREATMENTS

https://media.bnssgccg.nhs.uk/attachments/Commissioning_Policies_-_Jun_2018_v1819.1.01.pdf

"This document contains a list of all interventions that have been considered by the Commissioner and to which access has been restricted within the Bristol, North Somerset and South Gloucestershire (BNSSG) area." (This means that GPs can only refer patients in particular circumstances.)

Criteria Based Access and Prior Approval Policies
Acupuncture
Adenoidectomy
Alfa Pumps
Benign Skin Lesions
Blepharoplasty
Botox - Botulinum Toxin Treatment
Breast Reconstruction post-Cancer
Carpal Tunnel
Cataracts
Chalazia
Chronic Fatigue Syndrome / ME Referral for Adults
Continuous Glucose Monitoring Systems
CPAP for the Treatment of OSAHS
Desensitizing Light Therapy in the Management of Severe Polymorphic Light Eruption
DXA Scanning to help target Treatment in Adults at Potential Risk of Osteoporotic Fracture
Dupuytren's Contracture Release
Ectropion and Entropion Repair Surgery
EXOGEN Ultrasound Bone Healing System
Female Sterilisation
Foot Treatments – Surgical Options
Gallstones Removal (Laparoscopic Cholecystectomy)
Grommets – for Adults over 18
with Otitis Media with Effusion
Grommets – for Children under 18
with Persistent Otitis Media with Effusion
Grommets - for Children under 18
with Recurrent Otitis Media
Haemorrhoidectomy
Hernia Repair in Adults
Hip Replacement Surgery
Hip Surgery (Open or Arthroscopic) for Pain including Femoroacetabular Impingement
Homeopathy
Hysterectomy for Menorrhagia
Intrauterine Coil Insertion and Removal
in Secondary Care
Knee Arthroscopy and Irrigation
Knee Replacement Surgery
Laryngeal (Voice Box) Surgery
Low Back Pain and Sciatica in over 16s
Microsuction for Ear Wax, Discharge or Debris
Removal in Secondary Care
MRI Breast Screening
Nasal Treatment – Non Cosmetic (all ages)
One-Step Nucleic Acid Amplification
Open MRI Scanner at Cobalt Health Cheltenham
Paediatric Speech and Language Therapy
in Secondary Care
Penile Conditions - Surgical Opinion and Treatment including Circumcision - over the age of 18
Penile Conditions - Surgical Opinion and Treatment including Circumcision - under the age of 18 yrs
Polysomnography Tests for Children
Radiofrequency Ablative Therapy for the Treatment of High Grade Dysplasia in Barrett's Oesophagus
Raised Intraocular Pressure
Rectopexy and STARR
Reversal of Vasectomy or Female Sterilisation
Selective Dorsal Rhizotomy Post Op Physiotherapy
Shoulder Impingement Surgery for Subacromial Pain
Skin Camouflage Services
Spinal Surgical Opinion – Referral for Assessment
SpyGlass® Direct Visualisation Cholangioscopy
Strabismus or Amblyopia in Adults (Surgical Correction)
Syndactyly – Surgical Correction of the Fingers
Tattoo Removal
Tongue-tie Division Surgery
Tonsillectomy - Referral for Assessment (All Ages)
Trigger Finger
Varicose Veins Surgery
Vasectomy
Weight Management Service – Tier 3
Weight Management Service – Tier 4

Individual Funding Request Policies
Abdominal Loose Skin Removal
Anal Skin Tags
Breast Surgery – Female
(not post-Mastectomy for Cancer)
Breast Surgery - Male
Chest Wall Deformity, (Correction of)
for Cosmetic Purposes
Chiropractic Assessment and Treatment
Closure of Patent Foramen Ovale for Migraine
Congenital Ear Deformity Correction Surgery including Pinnaplasty
Cosmetic Contact Lenses
Cosmetic Surgery or Treatment
Diagnostic Dilatation and Curettage (D&C)
Divarication of Recti
Drop Foot - Surface Orthotic Functional Electrical Stimulation
for Drop Foot of Central Neurological Origin
Elective Treatment in Northern Ireland, Scotland and Wales
Epididymal Cysts
External Ear (Pinna) and Lobe Repair
Extracorporeal Shockwave Therapy (ESWT)
Facial Surgery and Treatment
Female Genitalia Surgery
Ganglion Removal
Hair Removal (including Electrolysis & Laser Therapy)
Hydroceles in Males
Hyperhydrosis Treatment
Ingrown Toenail
Laser Eye Surgery for Refractive Error
Laser Hair Removal for Pilonidal Disease
Liposuction to Reduce Fat Pockets and Deposits
Multifocal Lenses
Multiple Chemical Sensitivity (MCS) & Clinical Ecology/Environmental Medicine
Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary Incontinence in Adults
Population Screening outside of National Screening Committee guidelines
Post Clinical Trial Treatment
Skin Contouring
Snoring (Surgical Intervention for Simple Snoring)
Temporomandibular Jaw Motion Rehabilitation Devices
Testicular Prosthesis Insertion
Uvula Removal
Vitreous Floaters
Wigs, Hairpieces and Hair Replacement Systems

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.

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

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."

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.

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

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

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%.

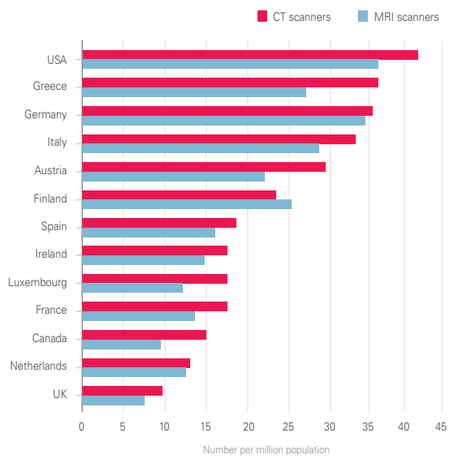
"It is unrealistic to expect the NHS to be a world leader in health technology when its capital spending on health care is much lower than in comparable countries, only a very small proportion of this is spent on IT, and spending on plant and machinery is declining." (p11)

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.

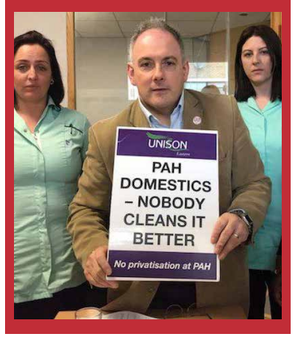
If that fails external conciliation service ACAS will be brought in and if there's still no agreement hospital staff may be forced to vote on industrial action.

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.

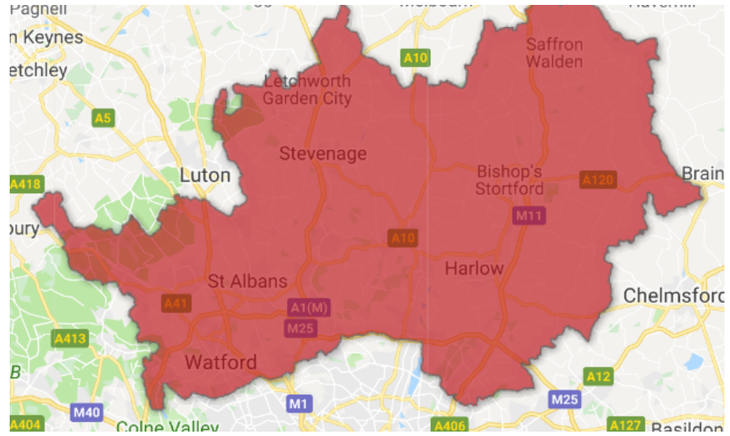
Meanwhile long-nurtured dreams of a massive redevelopment of a health campus to replace Watford General – for which the same STP apparently bid for another £600m of capital – were also brutally killed off.

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

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

The Lowdown launched in February 2019 with our first pilot issue and a searchable *website.*

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

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

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

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

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

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

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

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

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

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

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

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

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

Why is it needed?

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

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

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

In our first year we will:

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

Help us make this information available to all

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

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

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

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

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

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

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

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