THE lowdown

Health news, analysis and campaigns.
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Informing, alerting and empowering NHS staff and campaigners

PAH strike threat forces trust to keep services in-house

Domestics at Princess Alexandra Hospital in Harlow called off planned strikes after their employer dropped plans to outsource their jobs and pledged to keep the service in house.

The Trust had been market testing its cleaning and catering services with the aim of putting them out to tender.

Domestics voted by 99% to strike against the changes and were preparing to take six days of action, backed by UNISON.

Trump is not the problem: ministers are

Few people could have had any illusions that the British public would react positively to American corporations moving in on our NHS.

So what have we learned from the huge public reaction to the US Ambassador and then Donald Trump himself insisting that the NHS – and of course its budget of £120 billion a year – had to be on the table in any trade negotiations?

Tory leadership hopefuls predictably hastened to distance themselves from any toxic association with Trump's demands.

The public view was shown by over 300,000 people rushing to sign the petition launched by Dr Sonia Adesara, and promoted by Keep Our NHS Public, to "send a message to Donald Trump to keep his hands off our NHS, and ask the UK government to explicitly guarantee that it will never form part of a trade deal with America".

Trump himself appeared to retreat slightly from his original statement in an interview the next day with Piers Morgan; but it would be a mistake to take either his opening gambit or his subsequent statement at face value – or to trust any British government rejection.

Trump will have known that the NHS is already open to private companies to bid for contracts.

But up to now the main US health corporations have shown little interest in bidding for under-funded contracts to deliver patient care.

Nor are the major US insurers significantly engaged in the UK, even as gaps appear in the NHS. US hospital giants HCA and Tenet also have only a minimal foothold, but no large scale commitment to expand in Britain's small private hospital sector.

The Canadian government rejected any US involvement in their health care system, even while signing the NAFTA free trade deal

Instead US companies like UnitedHealth subsidiary Optum have focused on selling technology, IT expertise and "back office" systems. And of course the main potential money-spinner is pharmaceuticals, especially if Trump could strip away existing regulations and NICE guidelines, and force British prices up to the inflated levels they are able to charge in the US market.

The government have shown they are happy to accept all of these, except perhaps the drug price hikes, which would push up public spending.

So their denials are as phony as Trump's retreat. Remember it was British governments that created a competitive market in the NHS. They have opened it up to EU competition laws more than any other EU country.

It's been possible for governments, like the Canadian government, to reject any US involvement in their health care system, even while signing free trade deals.

France and Germany have also protected their much bigger health care against competition laws and have little if any US penetration.

It's not Trump or the US who have privatised sections of our NHS but British governments, and predominantly British companies such as Virgin.

To make sure we keep our NHS public, we need a government committed to do just that – not one led by any of the right wing hopefuls lining up to replace Mrs May.

IN THIS ISSUE

Brum trust gambles on Babylon's chatbot

John Lister

The massive £695m PFI-funded Queen Elizabeth Hospital in Birmingham is struggling with a rising tide of emergency attendances (up almost 8% since last year) and emergency admissions (also up by 8%); its 1200 beds are not enough to cope with local needs, the once prestige hospital is slipping down the performance league table – and its chief executive Dr David Rosser is getting desperate.

The scale of the emergency caseload is so great, with its pressure on acute hospital beds, that there is insufficient capacity to meet targets for treating elective patients, leaving numbers treated from Birmingham & Solihull CCG 11% below last year.

According to a paper presented by Dr Rosser to the Board on May 22 (but not yet available on the Trust's website):

"Patients who entered hospital on a non-elective pathway now account for over 90% of bed days across the trust so we have less than 10% of bed days to run our admitted, elective programmes."

"[…] to deliver our strategic aims and support future sustainability we must find ways to reduce unnecessary footfall at hospital, both outpatients and ambulatory care through ED, repurpose parts of the hospital estate to focus even more on acute and tertiary care, and better manage frailty and chronic disease in the community to reduce avoidable hospitalisation."

So desperate is the situation that the trust is looking to the unproven technological solutions offered by Babylon, the company behind GP at Hand, the online GP service controversially endorsed by health secretary Matt Hancock.

Babylon is led by Ali Parsa, the mercurial salesman best known for creating Circle Health, which runs small, unsuccessful private hospitals and which failed so spectacularly on a 10-year contract to manage Hinchingbrooke Hospital.

"Patients on a non-elective pathway now account for over 90% of bed days across the trust"

Parsa left Circle before it hit the buffers at Hinchingbrooke, and is now busily talking up what he claims is an "artificial intelligence" chatbot, and using this and a huge expansion of the workforce as the basis to attract up to $400m of investment income. The company lost money in 2016 and 2017, and appears to be spending contract income as soon as it comes in.

The UHB board has now agreed to explore using Babylon's services, including video appointments and digital triage, in the hope it might help divert pressure from its severely strained hospitals.

"We would like to explore whether an AI symptom checking tool, such as Babylon's AI symptom checker, currently designed for and aimed at primary care, could be developed for use in relation to urgent and emergency care. … Used in this way, it would provide the AI symptom checker through a chatbot, backed up by UHB's clinicians."

Just two days after the UHB board rubber stamped Rosser's plan, Hammersmith & Fulham published a worrying review by Ipsos Mori of Babylon's 'GP at Hand' system.

It pointed out that while GP at Hand appears to satisfy the mostly youthful and affluent punters who have signed up (94% of GP at Hand patients are aged 45 or under), the app offers little or nothing to many of the older age groups, who are likely have most need of health care.

But these are also the type of patient most likely to be among the rising numbers of A&E attenders Dr Rosser is trying to deter from coming to QEH. So it's hard to see how Babylon can help, even if it works as well as the company claims.

Work has begun on building a new £100m 138-bed private hospital on the QEH site as part of a partnership agreement between the Trust and US hospital giant HCA. HCA is financing the construction and will use 66 beds for private patients, leasing the remainder to the Trust.

The report also fails to answer key question of the cost-effectiveness or sustainability of the GP at Hand model. This is both because of "the absence of data on patient outcomes" (effectiveness) – but also because Babylon itself invoked "commercial sensitivity reasons" for refusing to divulge data on the costs of involved.

UHB is potentially thinking of signing up with a private company that will not share key information.

Dr Rosser is also burning any possible bridges by embarking on a policy that he knows will enrage Birmingham GPs. They were already angry at plans by Babylon to extend GP at Hand to Birmingham, which is likely to siphon off many of their younger, fitter patients who are cheaper to look after, and leaving them the older ones with greater health needs who will drive up costs.

The GPs have said they regard the potential deal with Babylon as the trust seeking ways to cut them out of deciding which patients should be referred to outpatient appointments with specialists.

They reject what the Local Medical Committee secretary describes as "an ill-thought through and destructive takeover".

So while most proposals for longer term integration of services recognise that primary care must be a key player, Dr Rosser has decided to put two fingers up to them, and trust in Ali Parsa's questionable company with its unproven app and its dodgy diagnoses.

It could end in tears.

Babylon covers its tracks

Babylon, the controversial company behind GP at Hand, which is destabilising primary care in London and set to extend to Birmingham, appears to be keen to cover up the traces of a discredited test of its online triage service last summer.

The company has been hard at work deleting all of the details of what was at first a much-vaunted comparative test, in which the chatbot's performance was presented as superior to that of real trainee GPs.

At first the company was quick to boast that this test proved that its software was superior to real doctors. But Babylon's claims immediately came under increasing critical fire from doctors and AI experts, who questioned the validity of the test, and revealed the various ways in which it was skewed to make the chatbot's performance appear better.

GPs consultants and IT experts also pointed out that, contrary to the incessant rhetoric from Parsa and others, Babylon's chatbot software is NOT based on AI at all, or even very innovative.

It is built on 'Bayesian Reasoning' – a system used to build systems in the 1970s. In other words meaning the chatbot has not been trained on a dataset, and does not "learn": it only knows what it has been told.

Contrary to the incessant rhetoric from Parsa and others, Babylon's chatbot software is NOT based on AI at all.

The many errors in its diagnoses which have been reported have only been corrected by human intervention, and by effectively reprogramming the machine.

'AI News' has since discovered that the video of the test event has now been deleted from Babylon You Tube account, and all links to the news coverage of the event have been removed from the company's website.

The link to Babylon's own conference paper describing the chatbot has also been deleted; in other words all of the company's boldest claims for the performance of the software now appear to have been quietly dropped.

When questioned about the deletion by AI News, Babylon's response was simply to add the excuse that "As a fast-paced and dynamic health-tech company, Babylon is constantly refreshing the website with new information about our products and services. As such, older content is often removed to make way for the new."

So yes, they have deleted the data.

critics have all argued that in real life the chatbot's results would be nowhere near as good as it appeared in the test, and that in some cases dangerously wrong advice could be given. Now it seems Babylon has given up trying to refute them.

The new Emergency department looks good – but the bed shortage is unresolved

New A&E building just makes matters worse in Croydon

Croydon's overstretched University Hospital has been bumping along at the bottom of the performance tables for some time.

In January 2019 it became the first hospital to dip below 50% of the most serious Type 1 A&E patients to be seen and treated or admitted within 4 hours. Indeed Croydon Health Services Trust's 29 percentage point drop over 2 years – to just 49.1% type 1 performance in January 2019 made it the worst in the NHS, 27 points behind the 76.1% average.

But now it appears that a contributing factor to this has been the opening of a brand new £21m A&E department, almost 2 years later than scheduled, last December: there had been problems with contractors, plumbing and asbestos.

But the new department, which the trust claimed had been planned with the involvement of medical and nursing staff, has proved to be a liability rather than an asset.

According to analysis by the South London Press:

"In the three months before the changeover, Croydon University Hospital's A&E was performing very similarly to the national average for Type 1 patients. … There was a small decrease in December, with an extra 5% of patients having to wait longer than four hours. In January, however, more than half of Type 1 patients in A&E waited longer than four hours to be seen."

In February the performance increased, but only to 63% of Type 1 patients waiting less than four hours, and in March it slumped again to 60%.

Croydon's trust's acute bed capacity decined from 523 beds in 2010/11 to 477 (plus a flashy new A&E) in 2018/19

By comparison Croydon's overall figure for Type 1 and Type 3 minor cases was much higher, with 85% in February and 84% in March.

The trust's response has been to blame the problems on a significant increase in demand for emergency admissions and the lack of available beds.

This is clearly a key issue. No matter how you enlarge the A&E as the entrance hall for patients, if the bed numbers are inadequate, performance will be limited.

This problem is a miniature version of the NHS as a whole, where huge amounts of management time and effort in recent years have been devoted to channelling away as many as possible of the less serious type 3 patients from A&E, even though these patients are not the ones facing the biggest delays and do not require beds.

Meanwhile they have been paying little attention to the growing delays for those in most serious need of attention.

Since 2010 the UK population has increased by over 4 million and the numbers of older patients more likely to need health care has also risen

However front line general and acute bed numbers in England have been cut by almost 6,000, with Croydon's trust's capacity declining almost 9% from 523 beds in 2010/11 to 477 (plus a flashy new A&E) in 2018/19.

Swindon primary care left stranded by contract failure

By Samantha Wathen (Media/Press Officer and writer for Keep Our NHS Public)

The future of 54,000 patients is uncertain after private company Integral Medical Holdings (IMH) has withdrawn from five Swindon GP practices it was contracted to run.

The mismanagement of general practice in Swindon and subsequent abrupt withdrawal of IMH means that five GP surgeries, over 100 members of staff and 54,000 patients now face an uncertain future.

Three partners are due to resign over the shambolic takeover of surgeries that took two practices from a CQC rating of good to requiring improvement or inadequate earlier this year.

Following an unannounced inspection at one of the surgeries affected Prof Steve Field, chief inspector of general practice at the CQC, said:

"We found there has been insufficient management infrastructure and insufficient leadership capacity and capability. There are significant concerns regarding the lack of effective governance and oversight to ensure quality and safety are not compromised."

Primary Care Networks will be introduced in a matter of weeks and NHS England have no plans to ease this deadline for the practices affected.

The way private company IMH has run the five GP surgeries in the town has meant significant problems for patients accessing appointments since autumn.

The arrangement was presented as a way to relieve the burden on clinicians to focus on patient care and ease the crippling financial pressures caused by sustained underfunding of general practice.

However, those employing this company should have done their homework. IMH have a troubled history.

In March 2017 the company hit the headlines when one of their practices in Kent was found to have five receptionists but no doctors after full time members of staff resigned, leaving the practice relying on locums.

There are also other examples of practices across the country going from a good CQC rating to inadequate as a result of an IMH takeover.

Dangerous practices

In Swindon the company quickly cut their costs by reducing essential administrative staff at practices by 50%. Without informing patient participation groups 75 staff were squeezed into the equivalent of 36 full-time roles, placing extra stress on those that remained.

A new call handling hub was introduced, immediately taking the time spent waiting on the phone to around an hour on average.

In addition, patients complained of dangerously muddled prescriptions, and long delays to access appointments.

According to a local member of staff working at the Great Western hospital one patient even required emergency surgery due to not being able to access their GP.

The situation deteriorated to such an extent that it drew the attention of the shadow health secretary Jonathon Ashworth who in November waded into the debate, raising the issue in parliament.

Following an unannounced inspection last month, the CQC issued IMH (now trading in Swindon as the Better Health Partnership) with an enforcement order to improve.

This prompted the resignation of Dr Peter Mack, the lead partner, from his director role at the CCG. IMH CEO Martin Diaper followed suit a week later.

After a protest outside the CCG by Keep Our NHS Public campaigners who have been exerting pressure from the start (photo above), the CCG finally informed IMH the contract had been breached, issuing a remedial notice requiring improvements.

The next day IMH announced their intention to withdraw from the five surgeries they were managing.

The abrupt withdrawal of IMH means five GP surgeries, over 100 members of staff and 54,000 patients now face an uncertain future

What next?

With hundreds of GP surgeries closing around the country the CCG and campaigners have a difficult time ahead but a solution must be reached, ideally with an NHS provider taking over the reins. Kate Linnegar, Labour prospective parliamentary candidate who has been campaigning on this with Keep Our NHS Public since the problems started, says:

"It's vitally important that the CCG oversee a smooth transition for patients who have suffered enough. Some NHS Foundation Trusts have taken GP surgeries inhouse, cutting out the need for a private profit-making company to be involved. I would urge Swindon CCG to consider this alternative."

IMH have effectively driven a wrecking ball through general practice in Swindon and should be held accountable. Private firms can and will walk away when the going gets tough, leaving the NHS to pick up the pieces.

The NHS cannot and will not do this, and that is just one reason why privatisation poses such a threat to our health system.

NHS England retreats – to insist lead providers must be NHS bodies

NHS England has made an ungainly climbdown from its initial plan to allow private sector providers to play a role in allocating specialist mental health commissioning budgets with a total of more than £2 billion.

In a move which Health Service Journal report links to criticism by campaigners of this new level of involvement of private companies, NHS England has written again to all providers of mental health, learning disability and autism services to make clear that private firms are excluded from leading the new models of care.

NHS England's letter includes public and private sector in an invitation to "all providers of specialised mental health, learning disability and autism services to make submissions, through a regional process, to form NHS led provider collaboratives from April 2020."

But it makes clear that the leading role in each collaborative has to be "**an NHS organisation** with experience of delivering specialised mental health and/or learning disability and autism services."

Victory for Liverpool ISS strikers

Hospital staff from all the main unions at Royal Liverpool and Broadgreen Hospitals suspended planned strike action on May 30 after a major contractor agreed to give them a pay rise.

The low-paid workers – who provide cleaning, porter and catering services – were due to walk out on Thursday May 30 2019.

But outsourcing giant ISS Mediclean agreed to match the same percentage pay rise other members of staff across the NHS have received – and back date it to the start of the 2018/19 financial year. Michael Evans, GMB Organiser, said:

"GMB members stood firm and - with the help of members of sister unions and Mayor Joe Anderson – they got the result they deserved."

Julie Simmonds

PET scanner issue not the only problem prominent on placards on a protest called by Oxfordshire Health UNISON on June 1

No end to Oxford's PET scan-dal

The fight against the privatisation of specialist PET-CT scanning services in Oxfordshire, Swindon and Milton Keynes shows no sign of abating, despite determined efforts to face down the protests.

Despite all-party pressure from MPs in Oxfordshire and from the Tory-led County Council, whose Health Oversight & Scrutiny Committee referred the case to health secretary Matt Hancock, he is refusing to review the decision to give the contract to a private company, InHealth. The Department of Health has also refused to respond.

Hancock has said that he will not step in because a "partnership" is being formed between the company, which does not have the specialist staff required to deliver the service, and Oxford University Hospitals Foundation Trust, which currently runs the service at the Churchill Hospital.

"Partnership" is a strange word to use for an arrangement in which the existing provider is pushed aside by an unwanted private company which is given control of the contract, but the NHS trust is then expected to work for the company to ensure the service is delivered.

Oxford East MP Anneliese Dodds has lodged a formal complaint at the scoring system used in the procurement, which resulted in the contract going to a company without facilities or staff to carry it out.

Meanwhile the local National Union of Journalists branch has called a public meeting to challenge the threats by NHS England to use legal action alleging defamation if the Trust or its staff speak out to expose the dangers to patient care posed by the contract.

The meeting on June 20 will argue "We all have a right and a duty to voice and report serious concerns". Speakers include outspoken cancer specialist Prof Adrian Harris, lawyer Tamsin Allen from Bindmans solicitors who has acted for whistleblowers and NUJ Deputy General Secretary Seamus Dooley.

What's the government's plan to help our GP services – and will it work?

PAUL EVANS

The pressure on GPs is evident across the NHS and a recent study shows that their numbers have actually fallen for the first time since 1960s. NHS England are calling on GPs to form new Primary Care Networks which they say will solve many of the current problems.

Being a family GP is not as desirable as it used to be. Patient demand is rising. Millions more are living with chronic conditions. Our needs as patients are more complex and often dealing with them won't fit into the average 10 minutes consultation time - the shortest in Europe.

GPs don't shy away from the challenge, but often when their patients talk about their symptoms they are also describing society's ills; family breakdown, money worries, social exclusion, which need a wide set of policy answers, not simply a prescription.

We now know that austerity has blunted our response, limited the treatment options and caused thousands of unnecessary deaths. Delays in mental health are dangerously high. Drug and alcohol services have been cut back, social care is by popular view on its knees and spending on preventing illness has gone down when it needs to be a high priority.

Its easy to see how a GP could be overwhelmed and demoralised and it's the reason why many are leaving the profession.

Plans to raise GPs numbers have been tried but have so far failed. Despite a government promise in 2015 to bring in 5,000 more GPs, data from NHS Digital shows that there are now 1,180 fewer than three years ago.

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PRIMARY CARE NETWORKS

In an attempt to lift the pressures on GPs, NHS England are reorganising primary care to help spread the workload. NHS England claim that the process is well underway.

"practices have begun working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas."

GP leaders are being asked to merge their practices together to serve larger groups of patients. These new Primary Care Networks will care for 30,000-50,000 patients each.

The vision is that GPs will work more closely with a wider group of health professionals including pharmacists, district nurses, community geriatricians, physiotherapists and podiatrists in 'expanded neighbourhood teams'. New money is already being targeted at these areas.

NHS England believe that introducing new ways of working will help to manage patient demand but also create better organised care that is more 'personalised' and more often sited in the community.

Commentators acknowledge the potential, but many point to the fact that there is a real risk that a lack of staff will derail the plans.

A BOOST IN STAFFING?

The NHS needs 7000 more GPs, but most of the health professions delivering care alongside GPs are also heavily overworked and understaffed. Nursing unions have pointed out that the capacity of community services has fallen sharply in recent years.

There has been a 50% fall in the number of district nurses between 2010-17.

There are a fifth less health visitors since 2015 and a 12% drop in mental health nurses over the last decade.

While the number of GPs has fallen the number of patients has risen by 16% more patients over the last seven years.

Gaps in other key area like social care have cranked up the pressure on primary care. Cuts in social care funding to local authorities have led to a 25% drop in the number of people that are accessing these services.

GPs confront the fallout from these vanishing services on a daily basis, dealing with patients whose health problems have not been caught early and doing what they can to help patch together the right care.

ENOUGH FUNDING?

NHS England acknowledge the staffing crisis and have set a goal to boost the primary care workforce by 20,000 in the next five years. Seventy per cent of the funding for these posts will come from government - £891 million of new annual investment by 2023/24, but PCNs must find the rest.

However, introducing PCNs will not bridge the existing capacity gap. NHS bosses agree that their number one problem is a lack of staff – as a whole the health service has a shortfall of 100,000 staff and counting. GPs and community services are bowing under the weight of current demand and yet NHS England intends for PCNs to take on far more work.

This reality should urge NHS leaders to argue more vigorously for the resources to raise NHS capacity, when they take part in the government's comprehensive spending review across the summer.

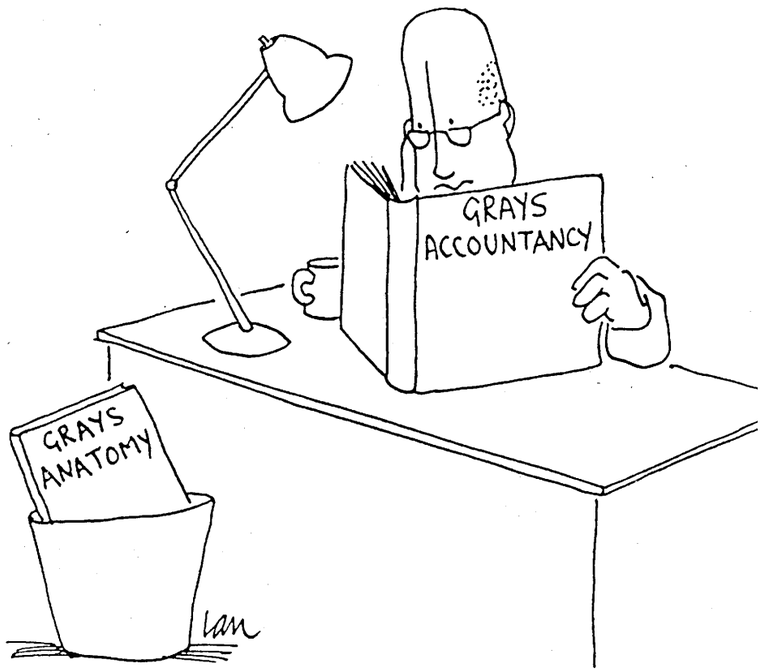
At local level GPs leaders are being incentivised to join PCNs allowing them to unlock access to extra funding. Most are complying, some are enthused, but most are desperate for an increase in real terms resources after a decade long financial squeeze.

PCNs will received an annual uplift of £1.50 per patient from CCGs and funding for extended opening hours and access. The government committed £4.5bn of the £20.5bn new funding it announced last summer to directly boost primary care.

The Health Foundation has criticised the size of the funding settlement and has also suggested it is unfair, saying that the extra money will not be shared out according to an equitable weighting system.

"networks servicing populations with the greatest needs will continue to do so with disproportionately fewer resources."

The Health Foundation has criticised the size of the funding settlement and has also suggested it is unfair, the extra money will not be shared out according to an equitable weighting system



REALISTIC EXPANSION?

From NHS England's perspective the need to get PCNs up and running is pressing. Many of the headline promises from their long term plan are ambitious, but have also ratcheted-up expectations.

At its launch NHS bosses proclaimed that their new 10-year strategy "could save up to 500,000 lives by focusing on prevention and early detection."

They want much of this to be delivered through primary care networks.

As they grow PCNs are expected to take on seven new areas of work including; structured medication reviews, enhanced health in care homes, anticipatory care (with community services), and work on early cancer diagnosis.

There is talk of dashboards and metrics to measure PCN performance. Part of the extra investment will depend upon their impact upon controlling A&E attendances, emergency admissions, hospital discharge and prescribing.

A further stand out promise from the long-term plan says that one in three patients are to receive care from newly enhanced community-based services, rather than going to their local hospital for an outpatient appointment.

This totals a startling 30 million clinic visits a year, patients which NHS England now intends to divert towards services in the community.

The detail on how PCNs will vault from their fledgling status into something capable of satisfying these sizable new demands is unclear, a fact which is leading commentators to suggest that NHS England has unrealistic ambitions.

The Kings Fund supports the move towards PCNs but think that they have a lot to contend with.

"there is so much that is still unclear and that could go wrong – a lack of development and workforce support, overly onerous performance management and managing relationships in primary care to name a few."

GP practice leaders are worried too that the new structures mask a likely increase in workload, over 50% supported this view in a survey reported on by GP online.

The detail on how PCNs will vault from their fledgling status into something capable of satisfying these sizable new demands is unclear …

A VEHICLE FOR PRIVATISATION?

A further concern is that PCNs will open the door for more commercial involvement in primary care. Virgin Care, Care UK and a host of smaller commercial outfits have been involved in running GP health centres and urgent care centres in numerous sites around the country.

A good number of these contracts have failed, after poor performance or profits have stalled.

Providers have then walked away. What room is there for private companies to exploit PCNs as a further business opportunity?

Louise Irvine a GP and campaigner against privatisation has analysed PCNs on behalf of Keep Our NHS Public. She believes that because the current GP contract (GMS) will remain in place the relationship between GPs and their local health commissioners will not change.

"Practices will not have to give up their patient lists to the PCNs, and patients will still be registered with their individual practice and receive core medical services from their existing practice team."

According to her analysis that primary care networks are not directly linked to recent drives to encourage private sector involvement.

"PCNs are very different to the proposed Integrated Care Provider (ICP) model, promoted by NHS England (NHSE), and which KONP vigorously opposes, whereby GPs would give up their practice contract and patient list and merge into a massive organisation covering upto hundreds of thousands of people."

However, one commercial provider - Babylon, has spotted an opportunity and has applied for its GP at Hand service to become a primary care network – a move that risks "destabilising" GP services in London, according to the London-wide local medical council.

Babylon is a private company that has sparked controversy by running a digital GP service for NHS patients, attracting 40,000 mostly younger patients from across the country, who in signing up to the London based service de-register from their existing local GPs who then lose funding.

The GP firm have perhaps been encouraged by the new government funding, although it is difficult to see how their digital service could work along-side the other professions in the health network.

A POPULAR SOLUTION?

So far GP organisations have cautiously supported PCNs seeing the chance to reorganise care with some much-needed new funding.

Everything rests on solving the workforce crisis and how these new organisation work in practice.

NHS England took the first step this week and there must be a dramatic turnaround in achieving these workforce targets.

However, the NHS England's ambitions for PCNs seem dauntingly large. Under their plans PCNs have a big part to play in shifting healthcare from hospitals into the community, for improving detection and outcomes and for adopting a raft of ground-breaking new technology.

It could well be too much for an already creaking service.

I hope those already knackered GPs weren't expecting a rest.

Billions are spent by the NHS on drugs every year – but how does it work?

How much does the NHS spend on drugs per year?

According to the most recent data from NHS Digital, in 2017/18 the overall drugs cost at list price in the NHS, before any discounts, was £18.2 billion.

This is an increase of 4.6% from £17.4 billion in 2016/17 and an increase of 39.6% from in 2010/11.

Hospital drug use accounted for just over half (50.4%) of the total at £9.2 billion (2017/18). In fact total hospital costs are up by 10.8%, compared to a 1% decrease in the primary care sector over the most recent year.

How are prices set in the UK?

Pharmaceutical products in the UK are priced by the manufacturer and are not subject to direct price controls.

Companies set the price of drugs based on a number of factors, including the number of patients it will benefit, how many similar drugs are on the market and the price of competing products.

Although, there are no direct price controls in the UK, the price of pharmaceutical products are controlled via indirect processes, discussed below.

The prices that the NHS will pay for a pharmaceutical product are published monthly in the drug tariff. This price is known as the list price and is normally what pharmacists will be reimbursed when they dispense the product.

How do prices in the UK compare to other countries?

It is not easy to compare drug prices across markets due to the complicated nature of rebates and discounts that operate.

It is however clear that drug prices in the UK are much lower than in several other developed markets and substantially lower than in the USA.

In 2017, the Commonwealth Fund investigated why health spending was so much higher in the USA, than in nine other developed markets, despite similar drug usage. Its conclusion was that

"While drug utilization appears to be similar in the US and the nine other countries considered, the prices at which drugs are sold in the US are substantially higher."

The report noted that the reasons for markets outside the USA, having much lower prices included certain price control strategies, like centralised price negotiations.

One example of high prices in the USA compared to the UK is the cost of insulin. A BBC story reported in March that retail prices in the US are around £220 per vial, for all insulins from the three major brands that control the market.

By comparison in the NHS there is no insulin listed that costs more than about £20 for one vial and many are much cheaper.

How does the NHS keep prices low?

For a pharmaceutical company, the NHS in the UK is the country's market; the private healthcare market is tiny in comparison to the NHS. If the NHS won't buy your products then you have no real market share.

"While drug utilization appears to be similar in the US and the nine other countries considered, the prices at which drugs are sold in the US are substantially higher."

Such centralised buying power gives the NHS the upper hand to a great extent in pricing negotiations and discounts based on volume sales.

On top of this buying power, prices are controlled through a number of indirect methods, including: a voluntary agreement between the industry and the government that covers the profit that companies can make on drugs; and for new drugs, an assessment by the National Institute for Clinical Excellence (NICE) of cost-effectiveness prior to a recommendation for use.

What agreements are there between the pharmaceutical industry and the NHS?

In the absence of direct price control mechanisms, successive UK governments have for many years relied on agreements with the pharmaceutical industry and market competition to keep drug costs from spiralling out of control for the NHS.

There is a voluntary agreement, renegotiated every five years, between the Association of British Pharmaceutical Industries (ABPI) and the Department of Health which covers the vast majority of branded products, i.e., those still covered by patents.

Under this scheme, originally known as the Pharmaceutical Pricing Regulations Scheme (PPRS), the industry members agree to a variety of measures to control prices and spending by the NHS.

The primary control is the payment mechanism, whereby members of the scheme make payments 'back' to the NHS if growth in NHS spend on branded medicines supplied by the scheme's members exceeds an agreed percentage.

In January 2019, the PPRS was revised and renamed the Voluntary Scheme for Branded Medicines. The cap for increase in costs to the NHS was set at 2%.

If in any of the next five years, the rise in drug spending by the NHS is above 2%, then the industry that has signed up to the scheme is required to pay back the NHS the overspend.

Around 80% of branded products are covered by the voluntary scheme. Branded products not covered by the scheme are included automatically in a statutory scheme, which also has a payback mechanism.

What products aren't covered by the voluntary or statutory scheme?

Generic medicines, those that are not protected by patents, are not covered by any price control scheme. UK governments have relied on market competition to control the prices of these products.

This has worked to a large extent, generic versions of best-selling branded products are sometimes 90% cheaper than the original branded products.

There has been a problem, however, with relying on market competition. Although a product may be old and produced as a generic, it will not necessarily have many or in some cases any competitors on the market. Some manufacturers took advantage of this situation and hiked the price of a generic product year-on-year knowing that there could be no comeback.

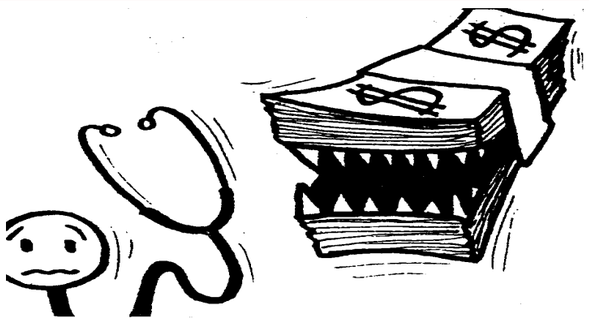
There have been cases where prices for some generics rose dramatically leading to a sudden increase in NHS costs.

An article in Pharmaphorum reported that dramatic price increases included the anti-epilepsy drug phenytoin sodium, the price of which was reportedly in-

continued overleaf, page 10

NHS our best defence against big pharma profit grab

Two instances of high drug prices are denying thousands of NHS patients the care they need, despite the power of the NHS in negotiations and indirect pricing controls, which for many years have kept drug prices in the UK low in comparison to the USA and other markets.



The Guardian has reported on the frustrated moves by the NHS to make the cystic fibrosis drug, Orkambi available to patients.

As the negotiations between the manufacturer Vertex and the Department for Health have reached a stalemate, parents of children who will benefit from the drug are planning on forming a buyers' club to obtain a generic version from Argentina.

Vertex, the manufacturers of Orkambi, has priced the drug in the UK at £104,000 per patient per year.

An identical version known as Lucaftor can be bought in Argentina for £20,000 per patient per year. The patent does not apply in Argentina, but the NHS can not obtain this product itself due to patent protection in the UK.

Orkambi was licensed for sale in the UK four years ago, but the National Institute for Clinical Excellence (NICE) refused to okay the product's use at such a high price in the light of the data available at the time.

There are 10,400 patients with cystic fibrosis in the UK, 40% of whom could benefit from Orkambi

In the summer of 2018, Vertex rejected an NHS offer of £500m over five years and potentially £1bn over 10 years for access to Orkambi and other cystic fibrosis drugs in the pipeline. A more recent offer has been made by NHS England, according to a report in The Guardian, but the situation has not been resolved.

Rationing care

In another example the high cost of a drug used to treat hypothyroidism has led local NHS planners (CCGs) to restrict its prescribing. Patients are now paying out of pocket for the drug and travelling to other markets where it is much cheaper.

Reports in the Daily Mail highlight the difference in price of the drug - liothyronine, which costs £204 for a 28 day supply in the UK compared to just £1 for the same amount in Greece.

As a generic drug, liothyronine is not subject to any price controls in the UK. As it is the only product of its type on the market, there is also no competition to bring down prices.

As a result, Advanz Pharma was able to increase its price substantially without any restriction.

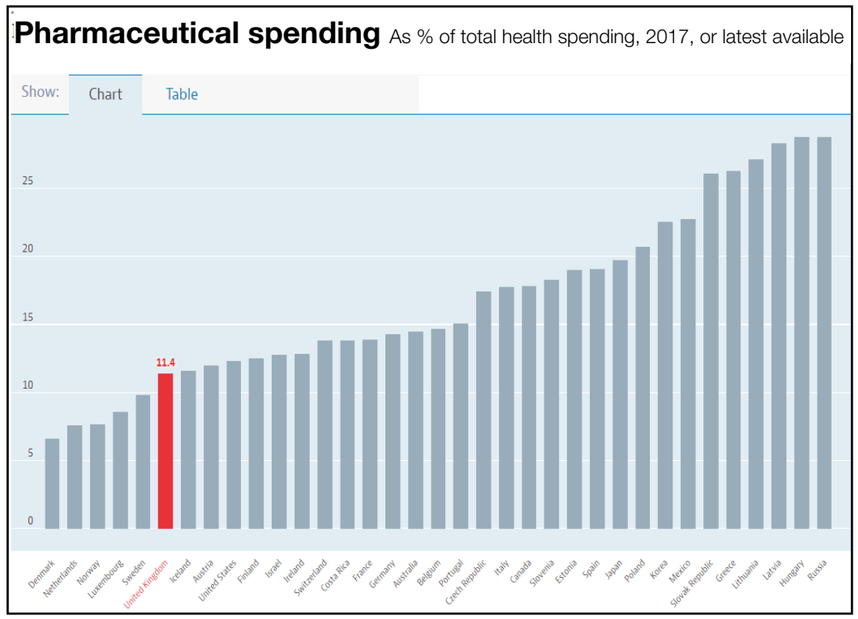
Over a period from 2009 to 2017, Advanz Pharma increased the price of a 28 day course from £5.15 to £258.19, up 1,605%.

As a result of the price rise, the prescribing of the drug was restricted to specialists and even in this situation, some patients were unable to get it on prescription due to restrictions.

In 2017, the Competition and Markets Authority (CMA) began to investigate the price hikes. Advanz Pharma maintains that it has not infringed competition law and all price increases were legal and approved by the Department of Health and Social Care over a period of ten years.

The CMA disagreed and has found that the company breached UK and EU competition law from at least 1 January 2009 to at least 31 July 2017.

Unfortunately for patients, despite the CMA's decision's the drug continues to be priced at £204 for a 28 day course, far higher than is acceptable to the NHS. The restrictions on prescribing, therefore, remain in place in many areas of the country.



creased by up to 2,600%.

The Competition and Markets Authority (CMA) has investigated these cases of dramatic price hikes. A change in law in mid-2017, however, should close the 'loophole' in the existing legislation that prevented the control of prices of unbranded generics supplied by companies that are members of the voluntary scheme for branded products.

What other ways does the NHS control prices?

New innovative products are assessed by NICE (National Institute for Clinical Effectiveness) for cost-effectiveness, using measures of improved 'quality of life' compared to existing therapies.

If NICE considers that the drug's effect on quality of life is not great enough to justify its price tag, then the drug is not recommended for use by the NHS.

The decisions by NICE often lead to discussions and negotiations with the manufacturers and the result is often a deal under which the NHS pays a lower price for the drug.

In particular, new medicines that NICE considers to be cost-effective, but which would cost more than £20 million in any of its first three years on the market are subject to price negotiations, in an effort to reduce the price. Unless a deal is reached, then NICE can delay access to the drug.

NHS England and individual NHS organisations also undertake negotiations with manufacturers for discounts, such as those based on volume use.

In November 2018, NHS England negotiated five deals with five manufacturers to get a cheaper version of one of the most expensive drugs used in the NHS, adalimumab, used to treat rheumatoid arthritis.

What happens when the drug pricing mechanism doesn't work?

Recent years have seen a number of situations where the drug pricing mechanism has failed and NHS patients have been unable to access certain drugs.

The failure to agree a price for Vertex's Orkambi, to treat cystic fibrosis, has resulted in many patients being unable to access what is the only treatment for this condition.

Vertex is refusing to reduce its price for the product, which the NHS says it cannot afford.

As already noted, in other cases, generic manufacturers have taken advantage of a loophole that existed for generic product prices and priced the product so high that the NHS has restricted its prescribing.

This has led to patients either not receiving the drug or buying overseas where the drug is much cheaper.

What will happen to drug prices post Brexit?

Drug prices and costs for the NHS will inevitably rise sharply under a no deal brexit scenario, according to the Nuffield Trust, which has investigated the scenario using data and reports from multiple sources.

The estimate was produced in November 2018, but the scenario still holds if we leave without a deal in October.

Other versions of Brexit will also increase the price of pharmaceutical products but by varying amounts.

According to the Nuffield Trust, a no deal Brexit will increase the cost of unbranded (generic) drugs by £830 million and branded drugs by £920 million by the end of 2019/20.

Overall, the cost to the NHS is estimated to be £2.3 billion by the end of 2019/20.

Some of these increased costs have already happened due to the effect on prices of the drop in the value of sterling after the EU referendum.

Mark Dayan estimates that this seems to have added around £500 million to the NHS trust deficits in 2016/17.

IEA pamphlet argues social care should be model for NHS

Anti-social model for social care – and NHS

What the (research) papers say

John Lister

A new pamphlet ***Integrating Health and Social Care – State or Market?*** was published by the Institute for Economic Affairs (IEA) with a flourish last month, but comes up with little that is new or particularly profound.

It reminds us that the IEA, a so-called "think tank" is really nothing more than an obscurely-funded right wing lobby group.

Perhaps the most surprising thing is that while exploring the problems of "integrating" the NHS (funded centrally through taxation, free at point of use) with social care (funded through local government, subject to means-tested charges), the IEA holds up the market-based, heavily privatised, and largely dysfunctional ***social care system*** as the model.

"Our integrated approach to medicine skillfully combines an array of holistic alternative treatments with a sophisticated computerized billing service."

Pamphlet author Philip Booth gleefully celebrates the chaotic jumble of organisations involved in social care, and argues:

"In order to achieve meaningful integration, we should make the health sector more like the social care sector so that there is more pluralism in provision and financing."

He goes on to set out the tortured logic of achieving 'integration' through separation and competition: "Providers could then compete on the basis of how they integrated different aspects of care."

Underlying this confused approach is the IEA's visceral hatred of planning and public ownership, and veneration of competition and markets – without troubling the reader with any evidence to demonstrate the benefits of these mechanisms, which have failed even more spectacularly in social care in England than they have in the NHS since the 1980s.

NHS model rejected

Prof Booth is appalled at the idea of integration on the NHS model, or even the much less specific parallel development proposed by the Labour Party in 2017 when its manifesto called for a properly funded National Care Service.

In Booth's view the key factor has to be a competitive market:

"The creation of a National Health and Care Service would involve ***rejecting the most important mechanism*** [i.e. competition] ***for ensuring the efficient use of resources*** and determining how health and social care should be provided and integrated." (p10, emphasis added)

"In order to achieve meaningful integration, we should make the health sector more like the social care sector so that there is more pluralism in provision and financing."

In passing the pamphlet does highlight a few interesting figures and the continued (poorly publicised) existence of "Continuing Healthcare" (CHC) rules.

These rules require the NHS to provide full funding to cover a package of care provided outside of hospital that is arranged and funded solely by the NHS for individuals aged 18 years and older who have significant ongoing healthcare needs.

Rising cost of CHC

While Prof Booth chooses to highlight the proportion of people turned down for this support, the National Audit Office in 2017 noted that "In 2015-16, almost 160,000 people received, or were assessed as eligible for, CHC funding during the year, at a cost of £3.1 billion." This spending is projected to rise to £5.2 billion by next year.

This is interesting, and may be news to many people who assumed that social care consisted of bundling understandably unwilling older people into poor quality nursing homes – while compelling them to sell their houses and liquidate their savings to pay for it.

However it has little or no bearing on Prof Booth's main line argument for markets and competition as the solution.

"Individuals could combine insurance with paying for other services out of pocket or with care provided by family and friends."

He moves on to two seemingly obligatory cursory – and again largely irrelevant – chapters on technology before moving towards the subject matter that most interests him. But even here there is little of any weight.

Eventually, on page 22 comes a sweeping assertion designed to shut us all up, spelled out in one gigantic 78-word sentence:

"Even if the contestable ideas of those who support significant state intervention in the process of innovation are accepted, there is no evidence that nationalising and centrally planning the entire system of provision of a service and determining the structure in which it is delivered from central government will provide an environment conducive to innovation in terms of either the integration of methods of delivery of different aspects of health and social care or the adoption of innovations." (p22)

It's true, of course. **There is no evidence of this, because nobody has ever attempted the type of centralised integration he is describing.**

Nor, therefore, is there any evidence it would ***not*** work.

Scandinavia

But there is good evidence in Scandinavia, where both health and social care are run as predominantly public services by the same local councils, that their system works much better than depending, as in England, on the shambolic array of poor quality private and voluntary organisations that now deliver most social care.

More to the point, Prof Booth produces no evidence at all to prove his own point, and show that it is possible to use competition to drive integration.

The final chapter, "conclusion and policy proposals" reveals that the real motivation behind the IEA's contorted thinking is its commitment to "social insurance models for healthcare which could then be extended to social care according to the preference of the insured." (p24)

Booth's bottom line is returning the NHS to a pre-NHS insurance-based system, with the prospect of top-up charges for health care as well as the charges many already face for social care:

"Individuals could combine insurance with paying for other services out of pocket or with care provided by family and friends." (p25)

This might delight the tobacco companies and neoliberals who fund the IEA, but it won't enthuse many voters.

THE lowdown

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

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

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – something that 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 regular one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally

Help us make this information available to all

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

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

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

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

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

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

On the website we will gratefully acknowledge all of the founding donations that enable us to get this project off the ground.

- Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG

- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at contactus@lowdownnhs.info