THE lowdown

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

Birmingham & Solihull staff united against WOS

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

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

Bradford strike to stay 100% NHS

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

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

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

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

Halted: plans to privatise urgent care in Halton

Paul Evans

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


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Evasive on privatisation – Hancock

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

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

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

Halton CCG is understood to have abandoned the procurement after considering the responses and the potential delays and costs involved in defending the decision.

Local GPs had raised concerns about the plans

The HSJ reported that One Primary Care are not considering their own legal action, but the CCG has not confirmed future arrangement beyond saying that they will continue with the current NHS providers in the short term.

Local MP Mike Amesbury, who joined a protest of UNISON members outside the one of the centres in Widnes told the Liverpool Echo

"This is an important victory and just goes to show what can be achieved when we all work together to fight for our NHS."

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

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

IN THIS ISSUE

Gaps exposed in social care

Tens of thousands of older and disabled people are being denied basic support such as help with washing and dressing as a result of almost a decade of budget cuts and now the government's failure to get to grips with the escalating financial crisis in social care.

The Association of Directors of Adult Social Services (Adass) reveals this and many other grim facts in its annual survey, which notes that nearly a fifth of councils now admit the quality of life for people using care has got worse.

Adass says social care in England is adrift in a "sea of inertia" caused by years of budget cuts and Brexit-related Whitehall policy paralysis – now compounded by the Tory leadership contest: the promised Green Paper has been repeatedly postponed and seems unlikely to appear until after the next election.

While both claim to be committed to solving the crisis in social care, neither of the two candidates to be the next prime minister has promised any new money.

Age UK has previously warned that tightening eligibility criteria for council-funded social care have left 627,000 people – nearly 900 a day – have been refused social care since March 2017. Estimates suggest 1.4 million older people now have unmet care needs, an increase of 20% in two years.

Councils spend on average 38p of every pound they spend overall on adult social care – up from 34p in the pound in 2010, but more than a third of them overspent their adult social care budget last year, many covering the extra cost by cutting other council services.

■ From a report in Health Campaigns Together on the new **Reclaim Social Care** campaign.

Shropshire trust boss dumped overboard

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

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

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

They are unconvinced by the clinical model put forward by SaTH that requires the closure of an A&E and downgrading of one of the two district hospitals.

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

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

We can assume that the CQC might be unhappy with the progress made.

The latest news on the maternity investigation will not have helped either. It has just been revealed that Donna Ockenden, leading a review of SaTH's maternity services ordered by the Secretary of State, is now investigating over 550 'cases of concern' including baby and maternal deaths.

That is over double the number of cases investigated at Morecambe Bay.

SaTH being found guilty and fined by the courts over an asbestos case is probably just the icing on the cake. But sacking the whistle-blower was probably not the most intelligent move.

Just after the fine was disclosed, it came to light that another building had to be closed for 6 months for asbestos removal – the building they spent half a million renovating last year. Just an oversight?

Shropshire Defend had called for Wright's removal. But it also has campaigned effectively on all the issues which might have forced him out. The Campaign provided significant material for both the CQC and maternity investigations provided by its supporters.

Campaigners like these will be heaving a massive sigh of relief as Wright departs

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

On Future Fit, the five-year battle has put the health bosses on the defensive time and time again. And the evidence provided has been sufficient for the IRP to halt the process at least temporarily.

It is not just in the acute sector that the Campaign has been successful. The CCG have removed proposed cuts to community hospital beds, closure of MIUs, and cuts to multi-disciplinary assessments of older people from their plans.

The reaction of a 600 strong public protest meeting in Ludlow, at which Philip Dunne, the local MP, was literally shaking as he tried to defend the health bosses, has eventually made them decide they could not risk putting these cuts out to consultation.

However, with the Shropshire health economy required to make £51.6 million cuts this year, the Campaign can only try to hold back the tide, without an increase in finance. The latest letter to the Campaign from Philip Dunne (who is Jeremy Hunt's campaign manager), shows the Campaign's political pressure is also becoming effective.

For the first time, he has admitted Shropshire needs more money: 'I shall continue to press for fairer funding for health'.

And the good news for Nottingham is that Simon Wright (whose record in the trust even prompted BBC social correspondent Michael Buchanan to comment that "I doubt there will be many involved in the provision of healthcare in Shropshire who will shed a tear over Simon Wright's departure,") has decided not to take up the job there. He is 'going to spend more time with his family' instead.

■ Based on an article by Pete Gillard, Shropshire Defend Our NHS, in Health Campaigns Together July 2019.

BMA votes to oppose racist NHS charges

The campaign to reverse reactionary legislation stemming from Theresa May's "hostile environment" to migrants has now gathered the support of almost all the professional bodies representing doctors.

In March the Academy of Medical Royal Colleges, covering all 24 medical royal colleges adopted a powerful statement rejecting the case for the charges and calling for the suspension of the regulations.

Now the BMA's 2019 Annual Representatives' Meeting has carried a motion (below) from Tower Hamlets which goes further and calls for the regulations and all charges to be scrapped.

The campaign has been led by Docs Not Cops and Patients Not Passports, and supported by Medact. Health Campaigns Together and Keep Our NHS Public have also supported vigorous protests in Liverpool, Bristol, Birmingham, Brighton, Cambridge and London.

The case has been forcefully made to refute cynical and hugely exaggerated claims by government and the right wing press that the charges are simply targeting "health tourists", and proving that the legislation is inherently racist, discriminatory, and contrary to NHS principles.

Health Secretary Matt Hancock has twice refused a call from the Commons Health and Social Care Committee to explain why the Department has refused to publish the outcome of its review of the charges, which apparently concluded that there was no significant evidence of overseas visitors being deterred from treatment or that the charges had had an impact on public health. On June 25 Hancock sent health minister Stephen Hammond in his place, who revealed under questioning that the review had not been on the impact of the charges since 2017, but on the more recent application of an amendment.

Hammond also admitted there had been no public consultation on the amendment, even though it transformed the "guidance" on checking eligibility for free treatment into a legal requirement to raise up-front charges

The "review," admitted Hammond, was carried out just six weeks after the change. Predictably (and conveniently for ministers facing questions in the house) it found little evidence of its impact. It is so flawed they have been determined to keep it from publication and even withhold it from the Committee.

Evidence continues to emerge of people being deterred from seeking treatment and inappropriately denied access to care.

Docs Not Cops

Motion by TOWER HAMLETS DIVISION:

That this meeting notes that in a pilot to check eligibility for free NHS care only 1/180 people were deemed ineligible and:

i) this meeting believes that it is not cost effective to monitor eligibility for NHS Care;

ii) this meeting calls for the policy of charging migrants for NHS care to be abandoned and for the NHS to be free for all at the point of delivery;

iii) that this meeting believes that the overseas visitors charging regulations of 2011 threaten the founding principles of the NHS and that the regulations should be scrapped.

UNSETTLED

Notice in Out-Patient Clinic: "NHS treatment is only automatically free for settled UK residents"

Dear Doctor,

This patient is unsettled, an unsettled UK resident.
He is unsettled about the weather,
Clouds dubious with rain, processing from the West
Like a crowd of grey-suited mourners.
He is unsettled about what to say and what not to say,
And the language is often ambiguous.
He is unsettled by people always saying "sorry".
He is unsettled by the newspaper
Referring to him as a cockroach.
He is unsettled that no-one else seems unsettled
About his plight.
He is unsettled by unsettling notices in hospitals
Warning him not to be unsettled.

The patient would like to be settled.
Please advise how he can do this.

Plum £1bn contract set to go private

An undisclosed private firm is the front runner to snap up a £1 billion 10 year contract to run community services – at a time when NHS England has tried to persuade trade unions, campaigners, concerned politicians and the public that they are trying to limit competitive tendering.

This latest, very large contract is being tendered out by privatisation zealots in charge of the Bristol, North Somerset and South Gloucestershire CCG.

The secretive process has been dragging on behind the scenes since January despite repeated efforts by Bristol West MP Karin Smyth, to stop it and call the CCG to account publicly for its actions.

The name of the winning firm is still under wraps until September, and CCG chief executive Julia Ross said to the governing body meeting on July 2 it was "not a foregone conclusion" that the preferred provider would become the contract winner.

The secretive process has been dragging on behind the scenes

What is a foregone conclusion is that this new exercise in privatisation will continue behind closed doors. Moreover the track record of CCGs in carrying out "thorough background checks" does not inspire confidence, and this secretive CCG has given no grounds to believe their approach will be any more rigorous.

In the unlikely event of organisation with the top score being ruled out by anything discovered during background checks, the CCG would turn to the bidder in second place, whoever that might be.

Either way the public will be none the wiser, and the privatisation process rolls on.

Implementation Framework published for Long Term Plan

Stand by for new round of secret plans

John Lister

The new NHS Long Term Plan Implementation Framework document published by NHS England and NHS Improvement was published well after Treasury Secretary Liz Truss confirmed that the spending review, expected to be completed in the autumn, has been delayed by the chaos in the Tory Party, and will not now report until the new year.

NHS England's hopes of agreeing five year plans by the end of the year were all conditional on the outcome of the spending review deciding how much revenue and capital might be available. Until ministers' decisions are known, many NHS plans will remain no more than wishful thinking.

However this problem is simply ignored in the Framework, giving the document an immediate air of unreality.

Once again, as with Sustainability and Transformation Plans three years ago, the Framework sets out a hugely ambitious and probably impossible timetable for rapid decision making and top-down change.

Draft plans need to be submitted by 27 September and finalised by November 15 (p32) – so expect a repetition of the secretive process that hatched up 44 largely useless STP plans in 2016. The Framework sets out the approach through which STPs and Integrated Care Systems (ICSs) should create "five-year strategic plans covering the period 2019/20 to 2023/24."

Workforce

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

To make the local task even more impossible the financial pressures on trusts and CCGs are being increased rather than relaxed: "Local plans will need to include the financial recovery plans for individual organisations in deficit against specified deficit recovery trajectories, with actions to achieve cash releasing savings including through the reduction of unwarranted variation and how they will moderate growth demand."

Local managers are required to guess the outcome of future government decisions: "Plans should set out capital investment priorities for capital budgets being agreed through the forthcoming Spending Review."

The Framework itself reveals that some of the so-called "priorities" in the Plan have now been elevated into "critical foundations" – which all areas must try to do at once.

This means a series of other priorities have been relegated to lesser importance, and effectively kicked into the long grass.

The priorities that have remained prioritised include **primary care and community services** (which are set to receive the largest allocations of additional funding up to 2023); **mental health** (receiving the next largest allocation of extra cash); **urgent and emergency care; cancer; increasing numbers of elective operations; 'personalised' care** (which always seems to be laid down in a one size fits all formula) and **digital primary care and reduction in numbers of outpatient appointments** – in line with the "digital first" mania in the Long Term Plan.

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

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

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

Exclusions

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

So the postcode lottery is not only alive and well, it is growing in scope. NHS England has taken no steps to ensure that CCGs with excessively long and unjustified lists, such as those which exclude routine referral for cataract operations, hip and knee replacements and other proven effective treatments, are forced to think again.

Sadly Star Trek's Dr McCoy's technologcal cures are fiction

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

In words the Framework commits to tackling inequalities: "System plans should demonstrate the key areas of inequality they will tackle and how additional funding is targeted" (p5)

In deeds, when Warrington & Halton hospital trust offered to allow patients who could afford it to pay for access to many "low value" treatments no longer routinely funded by local CCGs, Simon Stevens criticised the way they presented it rather than the two tier NHS they were threatening to open up.

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

Crisis response … or not?

In words the Framework commits to ensuring that "as a minimum" plans must focus on four things including "iii. improving the responsiveness of community health crisis response services to deliver the services within two hours of referral …" (p8)

However even as it was published it turns out that crisis-ridden Cambridgeshire & Peterborough CCG was discussing desperate cuts to reduce spending, including their emergency rapid response team for older people and patients with long-term conditions – which the CCG admits has "provided excellent patient facing care for patients".

There is no explanation of what the Framework means by "digital and online services" as options for quick elective surgical care (p13). It seems the fictional future technology of Star Trek is already a part of NHS England's plans.

For campaigners and health unions the Framework is a reminder of the scale of the challenge ahead to ensure services, and the funding for them are defended, and that the values and principles of the NHS are protected.

Private sector are winners from 'postcode lottery'

John Lister

Warrington and Halton Hospitals Foundation Trust has been forced by public outcry to suspend its controversial "My Choice" scheme which encouraged NHS patients to pay up front for access to dozens of treatments that have been branded "low value" and excluded from routine NHS provision by local CCGs.

According to HSJ reporter Lawrence Dunhill, Simon Stevens said the trust was 'misguided' in launching the self-pay scheme: Dunhill later clarified on Twitter that this comment referred to the marketing around the scheme - rather than the service itself.

However the inequality issues raised by the plan were immediately obvious – since many, especially older people who need these operations would not have the thousands of pounds required to pay for them, even at NHS prices: also obvious to many was the problem of opening up a whole area of the NHS in which charges become the norm.

Within 24 hours of the story being splashed over a Mirror front page, with mounting anger from local MPs and Shadow Health Secretary Jonathan Ashworth, trust bosses opted to pull the plan.

Soon afterwards in an unconnected but convenient move out of the limelight, Chief executive Mel Pickup, who had strongly endorsed the plan revealed she had accepted a new post as chief executive of Bradford Teaching Hospitals FT and "system leader" for the Bradford area.

But the underlying problem remains unresolved.

Seven CCGs in Merseyside and Warrington are still signed up to the same list of 71 treatments, including cataract and hip and knee replacements, which they say are of "low clinical value," and as a result the operations are not routinely funded by the NHS unless patients reach a high threshhold of need.

"Choice"

So patients in the area who are in pain but do not meet this threshhold have a "choice" of going private … or going without.

The CCGs hide behind the pretext of helping to "reduce variation" of access to NHS services in different areas ("sometimes called 'postcode lottery' in the media") and "allow fair and equitable treatment for all local patients."

Many other CCGs have adopted similar lists, with varying numbers of treatments regarded as outside the NHS for elective care: some CCGs have lists of as many as 104 treatments, some have as few as the 17 imposed by NHS England.

So in reality the 'postcode lottery' is back, with a vengeance.

However the only real winners seem likely to be the private sector.

With a private medical insurance market that "is at best static", and private hospital chains facing a reduction in income in many areas for treating NHS-funded patients in otherwise empty beds:

"a shining light for the sector is strong demand for private healthcare from self-payors. Despite a 9% real increase in self-paying spending, LaingBuisson projected a real fall in overall acute care market value for 2017."

Momentum Halton and Weaver Vale

Protesters opposing the 'My Choice' scheme to charge patients for access to "low value" NHS operations

This private market can only benefit from the NHS increasing the numbers patients who cannot access treatment on the NHS, or are weary of long waits for operations, and are able to pay up front for private care. Many such patients will be elderly or already suffering pre-existing conditions that means they are not eligible for or cannot afford private insurance.

Growth

According to private sector market analysts Laing and Buisson, "All the major UK hospital groups continue to report growth in self-pay patients, and as a result are marketing and developing their self-pay offering."

Income from self-paying patients has more than doubled from £493m in 2013 to £1.1 billion in 2017, according to a new "Self Pay UK market report" at the end of last year. Around 800,000 healthcare treatments each year are privately funded: in 2017 one in four of all private treatments were self-pay.

Prices for 'fixed price surgery' are now published on the websites of all major private providers. Laing & Buisson note that:

"it pays to 'shop around'. There are wide price variations for 'fixed price surgery' across the UK,"

They cite knee replacement prices varying from £9,559 to £15,202, while cataract surgery prices range from £1,650 per eye to £3,535. The varying prices have one thing in common: they are all out of reach of the poorest. And as CHPI research has pointed out the quality and safety of treatment in private hospitals give grounds for concern.

Seven CCGs in Merseyside and Warrington are still signed up to the same list of 71 treatments which are not routinely funded

Whether its private hospital chains or Foundation Trusts with their hand out demanding cash for routine treatment, the expansion of "self-pay" represents an erosion of the NHS, and a drift back towards the grim days before 1948 when millions could not afford to seek treatment and were forced to suffer in silence.

The starting point for this is the long and growing lists of exclusions. Last week it took an intervention from the Department of Health and Social care to prevent a decision by Cambridgeshire and Peterborough CCG to impose an indefinite ban on NHS funding for IVF treatment, to save money towards its £75m deficit.

Ministers must now step in to force CCGs elsewhere to remove the barriers they have put in the way of access to routine care under spurious claims that well-proven operations are of "low" or "limited" clinical value.

Our health in Boris Johnson's hands – what would he do?

Boris Johnson has questioned the use of what he calls "sin based taxes" to combat the national obesity crisis just days before ministers plan to extend the idea. So how will the frontrunner to become the next PM look after the nation's health? PAUL EVANS investigates this less explored aspect of his politics.

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

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

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

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

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

Meanwhile Johnson is punting in the opposite direction, asking for a review of the evidence, much of which is already sitting in our laps.

A study by the University of Cambridge in 2015 highlighted why a sugar tax could be so beneficial. Their researchers discovered that 8,000 cases of type 2 diabetes a year were linked to sugary drinks consumption. Since its introduction UK producers have reduced sugar content.

When a similar tax was introduced in Mexico sales of sugary soft drinks fell by 6% in first year. In France a sugar tax forced companies to reduce the sugar content by 30-40%.

In Berkeley, California a soda tax reduced consumption of sugary drinks by more than 50 percent.

A U turn on the sugar tax by a Boris Johnson led government would come as a bitter blow to all those who have fought hard for pressure on big business, against a powerful corporate lobby with strong links to the Tory Party.

In Berkeley, California a soda tax reduced consumption of sugary drinks by more than 50 percent.

New NHS shake-up?

This is not the first hint that a Johnson led government would take a different approach on health. At a recent hustings event he suggested that the NHS needed more re-organisation, saying it was "not getting the kind of support and indeed the kind of changes and management that it needs"

Details of how this would be done were scant, instead he reassured the audience of Tories that he would get together with Simon Stevens, the CEO of NHS England - an old pal from Oxford days, who helped him get elected to the Presidency of the union, to "sort things out". Over toasted crumpets no doubt.

More money for the NHS?

We learned recently that Johnson will not be prosecuted over his Brexit campaign claim that the UK sends £350 million to the EU every week, after the case – brought by campaigner Marcus Ball was thrown out by High Court judges. However, a quarter of people believed his promise that the NHS would benefit.

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

As foreign secretary, he marched into a cabinet meeting to demand £100bn for the NHS. A stunt trailed in the morning press, which did much to expose his leadership ambitions.

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

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

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

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

The decision over extra funding was to take place this summer in the government spending review, but in a painful

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irony the Tory leadership campaign has pushed this back, delaying any prospect of extra money for the NHS.

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

But what does he really think?

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

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

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

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

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

Open to persuasion?

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

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

How the NHS or any other domestic policy might be influenced by these far right associations is open to question, but the fact is Johnson is willing to go there, and contradicts his supporters claims that he is a "harmless" centrist Tory.

Full of contradictions

Boris Johnson can go misty eyed about the power of the NHS to care.

He described an emotional visit to an NHS unit where he met a young girl receiving treatment for her neurological condition, Johnson declared

"if she had been born in virtually any other country in the world, and if she had been born in any other epoch of British history, then she would have had zero chance of receiving that care."

There are signs too that he might clash with Matt Hancock, whose verve to see more virtual care in the NHS using apps, i-phones and skype to relieve the pressure on services seems at odds with most Johnson's recent comments.

"There is no robot that can provide that therapy. There is no app that can substitute for the patience and understanding of that young medic.

"You need a living human being to do that job, with a salary decent enough to allow him or her to live within reasonable distance of a hospital in London."

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

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

Others already smell the opportunity to set a new policy agenda.

The right-wing Institute for Economic Affairs has wasted no time in sticking the boot into Johnson's plan for extra spending, demanding that he end the NHS 'socialist experiment' and heavily reform the service. With their close links to Tory minsters public statements by the IEA will no doubt be closely followed by private lobbying.

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

As ever though the best defence will be a watchful and engaged public. As a populist, Boris will listen to the people - at least some of the time: and the people still want a publicly owned, well-funded NHS.

"The NHS is about as safe with them as a pet hamster would be with a hungry python," Major said

Bed shortage forces NHS to look to private sector

Sylvia Davidson

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

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

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

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

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

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

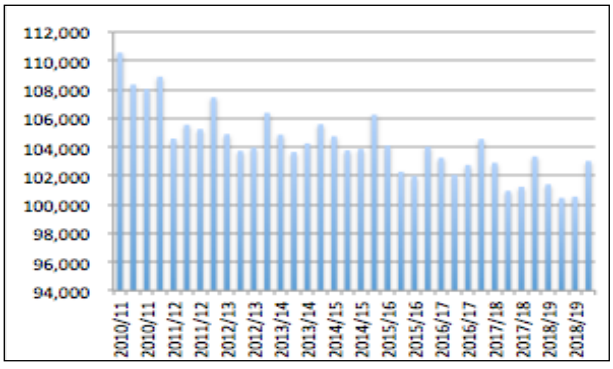
National bed shortage

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

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

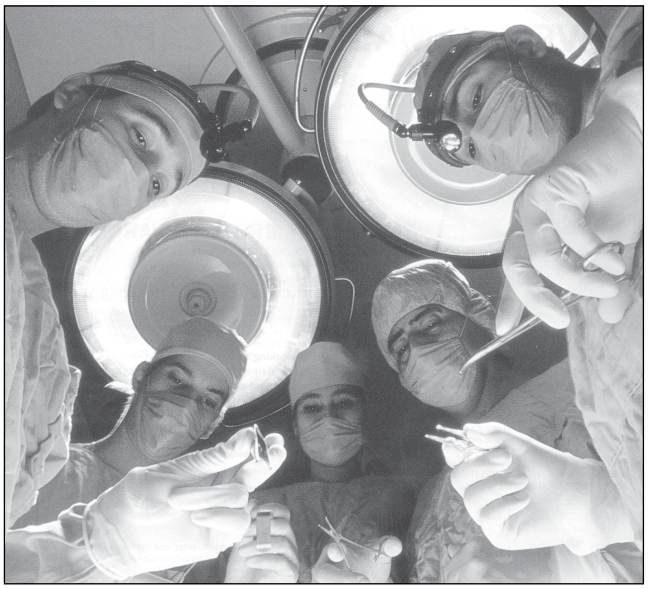
NHS trusts are under immense pressure to reduce waiting lists. The target is to treat 92% of patients within an 18 months maximum waiting time.

In response hospitals have been forced to seek capac-



Time series for general and acute beds - 2010/11 to 2018/19 - Source: NHS Digital

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



ity in the private sector. Figures for hip and knee replacements show how the role of the private sector has grown - in 2012/13 20.1% of knee and 13.7% of hip replacements were carried out in the private sector, but this had risen to 29.4% and 19.7% by 2016/17.

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

Urged to 'go private'

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

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

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

University Hospitals Plymouth Trust's 18 month partnership with Care UK will move 75% of its elective orthopaedic work to Care UK's neighbouring facility. The unit will be staffed by NHS staff but managed jointly by Care UK. By adding bed capacity, the trust hoped to improve its waiting times for elective orthopaedic surgery.

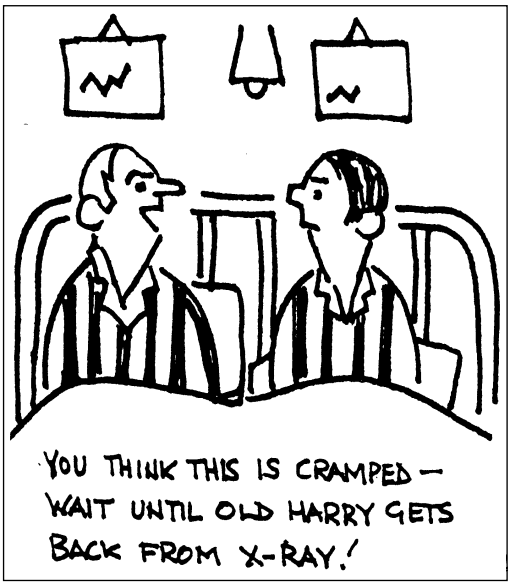
And in June 2019, Northumbria Healthcare Foundation Trust announced the signing of a contract with the private Rutherford Cancer Centre's facility in the North East for chemotherapy patients.

The trust noted that the partnership, which will initially treat around 120-150 breast cancer patients per year, is designed to help the trust ensure treatments for cancer patients are not delayed due to lack of capacity in the trust.

Despite the arrangements with private companies, at the end of March 2019, the waiting list was almost 6% higher than in March 2018. The only bright spot was a reduction in the number of patients waiting over a year for treatment, down 58% compared to March 2018.

Recognition from the top

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



the numbers of acute beds will have to increase over the next five years. Something that many people in the NHS have been saying for some time. Back in March 2018, NHS Providers chief executive Chris Hopson told HSJ it was estimated the beds shortage could be as high as 15,000 beds, 12% of the system's total bed base. Since this time, bed numbers have continued to fall.

Now a rise in bed capacity has received a seal of approval from the top, where will these beds come from? Will NHS trusts have the money and staff to open new beds or are the trusts going to be encouraged to seek additional capacity in the private sector?

Block booking

Will we see more block-booking of bed capacity in the private sector, as in Surrey, or the type of arrangement with Care UK in Plymouth?

In many cases the physical beds are there, just staff and/or money is needed to open them - the Guardian reported back in April 2018 that trusts had reported 82 "ghost wards" containing 1,429 empty beds that had been closed due to lack of staff and/or lack of money.

Of course, the private sector will be very keen on plans to increase bed capacity; the UK private sector is heavily reliant on the NHS and will have suffered a reduction in revenue due to the ban on elective surgery in the winter of 2017/18.

According to NHS Partners network, which represents non-NHS health organisations 515,000 non-urgent operations and surgical procedures were carried out by private clinicians for the NHS in 2017, about 6% of the total and the number will have risen over the last year.

Spire is one of the major private providers and NHS work contributed 29.2% of its total revenue at £272.2 million. According to its strategy outlined in its most recent annual report, "NHS waiting lists are getting longer and Spire Healthcare is part of the solution."

Imran's Photography / Shutterstock.com

NHS Providers remind us of the winter's tale

John Lister

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

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

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

Rising demand

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

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

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

Last winter:

- There were 6.1 million accident and emergency attendances, an increase of 5% from the previous winter and a 16% increase since 2014/15.
- On average, 66,300 people were being admitted in England each day over winter.

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

In particular during the 2018/19 winter:

- NHS hospitals admitted 1.62 million emergency cases, a rise of 6% from the previous winter and up by one in six (16%) since 2014/15.
- 4.3 million people are now waiting for elective treatment
- 3.9 million attending major A&Es. This represents a 6% increase on last year.
- There were 214,000 trolley waits over 4 hours recorded, and 1,465 of over 12 hours.
- 96% of trusts exceeded recommended occupancy levels.

Excluding 21st to 29th December, bed occupancy did not drop below 92% all winter. Croydon Health Services reported the highest average bed occupancy over the winter, with 99.6% of beds occupied, having been at 100% occupancy on most days over the winter

The total number of general and acute beds peaked at 98,826 this winter, down on 99,298 last year. [NHS figures show that in the winter of 2010-11 when the austerity regime first kicked in there were over 108,000.]

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

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

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

New performance measure

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

But NHS Providers' director of policy and strategy, Miriam Deakin said:

"We must ensure change is not recommended simply because the service is struggling to deliver existing targets."

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

What the (research) papers say

JOHN LISTER looks at three recent academic papers with relevance to NHS campaigners

With a current health secretary so openly enthusiastic to promote apps and digital "solutions" in the NHS it's useful to check on what level of actual evidence is available on how useful the new technology and software really is.

It seems there is relatively little appetite to find out – perhaps because those marketing the new digital devices and technology are less than keen to have it thoroughly tested. Only recently Babylon deleted any reference on its website to a high-profile test of its controversial chatbot which had appeared to show it competing successfully against real doctors, after the validity of the test was debunked by a number of experts.

Now a new study by a team of German academics of research papers on the existence, use and benefits of digital technology in relation to nursing care has responded to the "lack of good empirical overviews of existing technologies".

They have found few papers based on efficiency studies, and many studies based on "a low level of evidence". The authors point out prior to their study:

"To the best of our knowledge, there is no review article that outlines the broad range of technologies developed to support formal and informal care, and no research findings are available that outline the existing evidence with respect to acceptance, effectiveness and efficiency for this broad field of technologies."

The team conducted a review of research papers in German or English produced over a 7-year period up to March 2018. Their extensive online search led to analysing 715 full text articles from 69 countries.

The findings are interesting, but not entirely surprising given the current poor level of critical reporting and discussion of new technology.

Little evidence on cost effectiveness

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

There was also little focus in the research on digital support for informal carers: just 8% of papers considered this, while a vanishingly small number (less than 1%) saw children in need of care as a target group for digital solutions. Most of the studies were of technology for patients in need of care, or formal care givers.

The authors note that they found:

"large number of effectiveness studies with a focus on ICT, robots and sensors, and a large number of acceptance studies focusing on ICT, robots and EHR/EMR [electronic records].

"However, a large proportion of these studies has a low level of evidence …. Efficiency studies are very rare in general. This points to the low consideration of the relationship between benefits and costs of a technology, so far."

A large proportion of studies has a low level of evidence …. Efficiency studies are very rare in general.

The German team also note that the way their study had been organised made it less likely they would find any research papers critical of the new technology, almost all of which are to be found outside the mainstream of academic journals:

"We considered published scientific studies only, and no grey literature [research that is either unpublished or has been published in non-commercial form]. This review therefore tends to contain fewer publications with negative or neutral findings. Consequently, it can be assumed that there may be a bias towards promising technologies."

Fines are a blunt instrument for cutting hospital readmissions

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

The authors begin by stressing that "Hospital readmissions are common, costly, and – as they are often preventable – a marker for poor hospital quality."

The penalties announced in 2010 and imposed for certain medical treatments from 2012, and soon afterwards extended to some surgical patients, were large:

"The penalties were substantial in size: up to 3 percent of Medicare's base diagnosis-related group payments for each diagnosis in question, which is a ten- to fifteenfold larger incentive than pay-for-performance initiatives to reduce mortality.

How useful are NHS business cases?

In our last issue Richard Bourne pointed to the weakness of many 'business cases' setting out proposed changes in the NHS, and challenged the frequency with which commissioners and providers resort to spurious claims of "commercial confidentiality" to avoid disclosing the extent of this weakness.

Now a new research paper has for the first time attempted to develop "quality indicators" for healthcare business cases. It has many weaknesses, not least in accepting without question the claims that an undisclosed number of the business cases they examine were of a "confidential and sensitive nature," and therefore offering no specific critiques of identifiable business cases.

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

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

Moreover, no doubt partly because of the researchers' limited and rather naïve approach, none of the questions they ask of business cases includes any critical appraisal of the honesty and integrity of the documents, and no check on the assumptions made or the quality of the so-called 'evidence' on which the business cases are based. There is no serious discussion of equality issues.

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

Indeed many business cases are little more than cynical PR spin to sell a proposed change rather than a serious and critical exposition of the facts.

The researchers' lop-sided approach is made worse by the fact that rather than assessing major business cases in the public domain, they chose instead to "maintain ongoing dialogue with identified 'gatekeepers' within the CCG to gain access to business cases."

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

These criticisms tend to focus on the merits of the changes being proposed, the 'evidence' produced, the practicality in terms of funding and staffing, the viability of the plans, and the needs and views of the communities affected.

The authors, from Bristol and Birmingham universities, do howeve recognise that: "a 'poor' business case may lack persuasion or, in more serious cases, misinform decision-makers about the relative strengths and weaknesses of available options."

They correctly make the point that bigger does not mean better: "Longer business cases were not necessarily any better at providing full coverage of the quality indicators, indicating that length alone does not necessarily guarantee quality."

They also note that "only one business case explicitly linked its proposal to a set of local needs."

However they go on without any sense of irony to discuss the application of the 'SMART' approach (specific, measurable, achievable, realistic and timely) despite having found that fewer than half of the NHS business cases analysed (7/15) even included explicitly labelled aims or objectives.

To progress beyond this limited exercise the authors would do well to break away from their debilitating ties to the CCG and begin talking to campaigners who have made detailed and successful challenges to business cases – in Shropshire, Huddersfield, West London, South East London and elsewhere – and to trade unions who even now are challenging business plans that seek to justify hiving off staff into "wholly owned companies".

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

"A recent survey confirmed the profound influence of the HRRP's penalties: Following the implementation of the policy, 66 percent of hospital leaders reported that the program had a "great impact" on readmission reduction efforts, and nearly half reported that readmissions were their top priority."

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

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

In fact the authors suggest "Our findings also suggest that readmission reductions may be approaching a "floor," and that a certain level of readmission "may be necessary and a sign of appropriate care for surgical patients."

The authors go further, noting evidence that penalties for readmission "may have actually ***increased mortality*** for certain conditions, as some patients who should have been readmitted were instead discharged from the emergency department and died at home."

Hospitals that received penalties tend to serve more minority and low-income patients

There are also equality issues arising from the penalties:

"For instance, it is widely accepted that hospitals that received penalties tend to serve more minority and low-income patients and that their readmissions may reflect a failure of the social safety net rather than of their medical care. Safety-net hospitals bear the brunt of readmission penalties, and disparities may be widening at these facilities as they struggle to execute their mission in the face of sizable penalties."

The report tacitly admits that a factor in reducing readmission is properly coordinated discharge and support outside hospital – a factor which is of course a recurrent issue for the NHS.

In fact the penalties may have played a relatively minor role: the paper argues that provision of such joined up services by accountable care organisations "could have contributed to the observed decrease in readmissions."

Nevertheless, the authors are reluctant to recommend any relaxation of the penalties in the US. They believe repealing the program "would remove the strong financial incentive to coordinate care at discharge and could bring readmissions back to pre-policy levels."

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