THE lowdown

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

Merger plans are seeking to flout the law

Campaigners call NHS England's bluff on CCG mergers

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Across England there are plans to merge Clinical Commissioning Groups: according to the HSJ, 86 of the remaining 191 CCGs are planning to merge into much larger bodies covering up to 2 million at a time. This threatens to marginalise any local voice or accountability for patients and the public in dozens of areas.

In South East London the six CCGs are to be merged into one covering a population of 1.8 million people; in North West London eight CCGs have been planning to form a single, monster CCG which campaigners fear will be largely impervious to the needs or demands of 2.2 million people.

Many if not most of these mergers are going ahead without any public consultation. This is important because the scrapping of locally based CCGs would remove the already limited level of public democratic accountability. At present each CCG must meet in public, publish board papers, and consult on changes.

211 CCGs were set up in 2012, when the Health and Social Care Act amended the previous 2006 Act. Their task was said to be to commission the majority of health services for their population.

"Local" and accountable

Indeed CCGs were initially portrayed as local organisations: when they were first proposed in the ridiculously-named Liberating the NHS White Paper in 2010 the promises of local democracy were extravagant:

"The Government's reforms will empower professionals and providers, giving them more autonomy and, in return, making them more accountable for the results they achieve, accountable to patients through choice and accountable to the public at local level".

Subsequent guidance insisted that, contrary to current plans: "CCGs' vision and plans will be accessible to a diverse range of communities and groups … to enable CCGs to be leaders in sustainable healthcare and accountable to the population they serve. … CCGs will have a strong sense of place."

Of course the real reason for establishing CCGs was to promote the marketisation of the NHS by compelling CCGs to put services out to competitive tender: the promise of a greater local say over services was only window dressing to make CCGs palatable. In practice most CCGs have failed to live up to this expectation and have generally ignored the views of the public and failed to engage front line clinicians.

Local GPs had raised concerns about the plans

But there have been some important exceptions, most notably Lewisham CCG which joined with the public and Lewisham Council in successfully opposing plans to close Lewisham Hospital.

Any such potential will be lost when the CCGs are merged into giant, remote organisations: that's why this merger process is being driven from the top.

Now Lewisham Hospital campaigners are demanding that there be full public consultation on CCG merger plans – and they believe they have the law on their side.

The campaigners have gone back to the amended NHS Act 2006 which (14G) stipulates that CCG mergers involve both the dissolution of the pre-existing CCGs and the formation of a new CCG.

And they have found that according to the Regulations governing the implementation of the Act, dissolution of a CCG requires the CCG to seek the views of all the people in the CCG area. Indeed, whether the CCGs are being dissolved, varying their constitution or changing their areas and memberships, the Board authorising the change is supposed to assess:

"The extent to which the CCG has sought the views of individuals to whom any relevant health services are being or may be provided, what those views are, and how the CCG has taken them into account" (Schedules 2 and 3).

This means a public consultation is required and not the partial "engagement with stakeholders" that is currently taking place.

More of the legal details are available to assist campaigners, councils and scrutiny committees wanting to defend the last vestiges of local accountability in the NHS: see the information posted by the Save Lewisham Hospital Campaign.

IN THIS ISSUE

What does the US want on the table?

John Lister

Since Donald Trump first let slip that he wanted the NHS to be "on the table" in any trade deal with the US after Brexit, debate has continued on exactly what might up for grabs as a result.

The belated and repeated statements from PM Johnson and Trade Secretary Liz Truss that there was no question of putting the NHS "up for sale" lack conviction, not least because flogging off the whole NHS was always the least likely outcome: there are so many parts of the NHS that US corporations seeking profits would find unattractive.

It's also the case that especially since the Health & Social Care Act of 2012, US corporations have been free to bid for contracts to run NHS clinical and support services. So far not many of them have done so: the greatest inroads have been im mental health.

But as a recent article by Kate Ling of the NHS Confederation points out, even operating on World Trade Organisation (WTO) terms after leaving the EU without a deal won't force commissioners to invite bids from overseas companies to provide NHS services:

"It will be for the Government of the day to choose, when negotiating, what kind of services foreign providers can bid to supply."

This will not fill many campaigners with confidence. Of course the driving force so far in privatisation of NHS services has been the British government, whether that was New Labour from 2000, David Cameron supported by Lib Dems from 2010, or Tory governments since 2015.

However the US is most likely to focus not on taking over services but on other highly lucrative areas, notably the pricing of medicines – seeking to dilute or remove the agreement with the pharma industry under which the NHS caps its expenditure on branded medicines, paying far less than in the US.

The driving force so far in privatisation of NHS services has been the British government

The US pharma giants would also like to strengthen intellectual property rights for companies who hold patents and data about the drugs they market, which could delay patient access to cheaper generic drugs.

There is also the threat they might push for access to the British NHS's unique database of 55 million patient records, which have been estimated to be worth £5 billion per year to private companies. Consultancy.uk has highlighted a recent paper from professional services giant EY which claims that the NHS could tap into a vital source of funding by opening up its patient records to private entities.

The NHS Confed also says it is concerned to prevent any further inroads into the NHS. It urges government action (changes in the law) that would "Ideally, exclude publicly funded healthcare services completely from the scope of a future free trade agreement (FTA).

"Or, if they are within scope, explicitly exempt them from commitments that would, for example, oblige the NHS to allow the trading partner's companies to bid for NHS business…."

However the Confed says it is happy to allow commissioners to choose to put services out to tender.

In other words even if we can keep the Americans at bay, the real challenge in pressing to keep our NHS intact is to stop our own home grown CCGs and Trusts ***choosing*** to put more NHS services out to tender.

CCG mergers spreading like a rash over England

John Lister

The top-down drive to force through CCG mergers, as discussed on our front page, is at its most frenetic in London, where 32 CCGs could be reduced to just five if current plans are rubber stamped by NHS England.

In North East London Hackney Healthwatch has raised the question of whether City & Hackney CCG's days are numbered, given the lack of any public discussion or consultation as plans progress to merge seven CCGs into one. City & Hackney CCG dodged a series of direct question on the plans for merger, and it's clear there are no plans for public consultation.

In North West London, as previously highlighted in The Lowdown back in June, the same eight CCGs that tried and failed to force through their half-baked Shaping a Healthier Future plan to axe hospitals and beds, are now seeking a merger to form a mega-CCG covering 2.2 million people.

They hope it would clear the decks to push through controversial plans by closing down the individual CCGs, and thus making it easier to ignore community views and boroughs like Hammersmith and Fulham and Ealing that might speak up for the needs of local people.

In South East London, six CCGs could also be merged into one, again gagging the more responsive and progressive voice of Lewisham CCG by eliminating it from the scene. CCGs South West and North Central London are also set for merger, regardless of the opposition from local boroughs, which could only influence decisions if there were a formal consultation.

According to the HSJ a further 17 areas are planning to make applications for mergers – among them Kent and Medway, Durham and Teesside, Staffordshire and Stoke-on-Trent, and Herefordshire and Worcestershire.

September deadline

There is a September deadline for 2020 merger proposals, each of which will need approval from NHS England. It's claimed that mergers would offer cost-savings and the development of system working, but it's clear any such savings would come at a cost of reduced accountability and local engagement.

The *HSJ* notes that, as with efforts to create "integrated care systems" a potential obstacle to the merger process is the financial impact on areas whose CCG is in a relatively healthy position, as they merge with others deep in the red.

But top-down pressure for merger, combined with an apparent determination to push the process through behind the scenes to avoid public debate and disclosure, seem likely to be the most decisive factors – unless campaigners can manage to force CCGs and NHS England to comply with the regulations they are currently ignoring.

Top-level censorship on NHS Brexit problems

So-called "arm's-length bodies" including the Care Quality Commission, NHS England, NHS Improvement, Public Health England, and the National Institute for Health and Care Excellence face having any statements on Brexit vetted and censored by the Department of health to ensure they are in line with the "top lines from the core EU exit script."

Statements will have to be cleared by the Department before publication, according to a memo seen by the *HSJ*. This represents a tougher restatement of the edict in February, again publicised by the *HSJ*, demanding that "every piece of communication, from an email to suppliers, a letter, press notice and, in this case, texts and phone calls to the public, need to be flagged, and cleared" by DHSC director of communications Rachel Carr and her team.

The *HSJ* reported back then on the immense bureaucracy and delays created by this heavy censorship of regular communication to ensure that only the government's views are expressed:

"The clearance process involves ALBs sending all relevant communications to named communications officers from the DHSC who then check with the department's EU Exit policy team, followed by clearance through the head of EU exit communications and ministerial private office, according to the email.

"Communications which need clearance by ministers are sent to them at 12pm each day. Anything which needs clearance by the DExEU takes an additional two days."

More worrying, Sky News has also revealed that the government has issued hundreds of gagging orders (legally binding non-disclosure agreements) to help cover up the actual state of play in many sectors, including 26 to keep a lid on problems at the Department of Health and Social Care.

It seems Johnson's government will devote its main energies to suppressing information and discussion of the problems their own policies are creating.

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In denial

The one substantive government report on the likely post-Brexit disruption that has been leaked to the media, the Yellowhammer report, was immediately dismissed as hopelessly out of date by ministers: but experts and eagle eyed reporters such as the BBC's Faisal Islam have shown it to be very recent, and the *Sunday Times* which leaked it reported it was compiled in August.

But as Labour leaders and public health expert Professor Martin McKee have since argued, if the document really is out of date, ministers should publish the new one to reassure health staff, patients and the public that the problems it identifies – not least on the complexity and time constraints of importing medicines from the EU have been addressed.

Suspending parliament to push a no-deal Brexit would be catastrophic for patients

Statement from TUC and 10 health unions

Together we represent more than a million health and care staff.

They're the lifeblood of our health service, consistently going above and beyond to make sure we can all rely on world-class care when we need it most.

A no-deal Brexit could devastate the NHS and social care. And if this government goes ahead with it, health and care workers will be on the frontline.

As the Yellowhammer report makes clear, a no deal could cause significant disruption to the supply of medicine, lasting up to six months.

Many medicines, including life-saving agents for cancer diagnosis and therapy, cannot be stockpiled and for those that can, stockpiles could run out.

These kinds of shortages and delays can be fatal. No responsible government should take that risk.

We have already seen thousands of EU staff leave since 2016. In the event of a no deal, tens of thousands of NHS and care workers from the EU would be left in limbo, intensifying the largest staffing crisis in the services' history.

Ministers must unequivocally guarantee the right of European health and care staff to continue to live and work in the UK.

Finally, we know that the stronger our economy, the more funding we can dedicate to the NHS and social care.

Treasury assessments show that a no-deal scenario would shrink our economy by £90bn, reducing the money available for the NHS and other vital public services.

After a decade of austerity, health and social care budgets across the country are under immense pressure.

With many care providers already in difficulty, a hit to the public finances could have additional knock-on consequences for the NHS.

With waiting times rising, operations being cancelled and yet another winter crisis looming, the health service cannot weather a long-term economic shock.

We call on the government to take no deal off the table.

Frances O'Grady, General Secretary, TUC
Dave Prentis, General Secretary, UNISON
Dr Chaand Nagpaul, Council Chair, British Medical Association
Donna Kinnair, Chief Executive and General Secretary, Royal College of Nursing
Gill Walton, General Secretary, Royal College of Midwives
Tim Roache, General Secretary, GMB
Gail Cartmail, Assistant General Secretary, Unite
Karen Middleton, Chief Executive, Chartered Institute of Physiotherapy
Richard Evans, Chief Executive, Society of Radiographers
Sam Aitkenhead, General Secretary, British Orthoptic Society
Annette Mansell-Green, Head of employment rights, British Dietic Association

New round of moves to downgrade A&E services

John Lister

It has taken some time for some of the cutbacks proposed by the Sustainability and Transformation Plans drawn up behind closed doors in 2016 to percolate through, but a new round of downgrades and cutbacks in Accident & Emergency services appear to flow from the need for massive savings – and from the continued chronic failure of government or NHS England to tackle the growing shortages of nursing and medical staff.

Indeed staff shortages are the convenient excuses put forward for fresh efforts to downgrade A&E departments in Tyneside, Lancashire, Gloucestershire and Cambridgeshire.

South Tyneside

In **Tyneside** the Northumberland, Tyne, Wear and North Durham STP set out plans in response to a claimed £641m gap in the health system by 2021: NHS staff, unions and campaigners warned of concerns that

"… with references throughout the STP to the need to reconfigure services and the problems sustaining seven acute hospital sites, that **the South Tyneside FT and Sunderland FT coming together to be managed under a single management could be a prelude to a merger in which one hospital or the other would be downgraded** – leaving patients from the other area to travel much further for treatment."

The two trusts have merged, and now, as predicted, the pressure is on to strip out services from South Tyneside Hospital to "centralise" them in Sunderland.

Some stroke, paediatric and maternity services have already been moved to Sunderland – but more services are at risk: the next phase of the so-called "Path to Excellence" scheme involves changes to emergency care, surgery, diagnostics and outpatient services, effectively downgrading South Tyneside to an elective treatment centre with urgent care.

Since 5th August children's A&E services in **South Tyneside Hospital** have been closed between the hours of 10pm and 8am: this will affect 3,600 children a year. Senior consultants in the trust report that the numbers of children attending A&E almost quadrupled from 6,000 in 2012 to 21,000 in 2018. Every cutback further undermines the hospital's future as a District General Hospital.

The only reason holding up this next change is the shortage of capital. But astoundingly it seems that local councillors could step into the breach and enable the trust to go ahead. Ken Bremner, chief executive of the merged Trust, has said if NHS funding is not forthcoming local councils could offer support to the scheme.

In July campaigners took to the steps of South Shields Town Hall to protest at the possibility of South Tyneside and Sunderland councils using their borrowing powers to raise up to £50m capital … to fund changes that would further cut back their own local hospital services. The lion's share could come from South Tyneside Council.

Save South Tyneside Hospital campaign chair Roger Nettleship warns that the main reason for this is because NHS chiefs "want the council to buy-in to this second phase without knowing what it's going to be. If they buy into it, then they're most likely to not oppose the services that will be lost. The scrutiny committee did a brilliant job to oppose the phase one when they referred it to the secretary of state. There won't be that same impetus to do that if they're funding phase two."

Staff shortages are the convenient excuses put forward for fresh efforts to downgrade A&E departments in Tyneside, Lancashire, Gloucester-shire and Cambridge-shire

Chorley

In **Chorley in Lancashire** the process of downgrade of the Chorley and South Ribble District Hospital is more advanced: its A&E closed completely for much of 2016 citing staff shortages, and depite the efforts of campaigners is now functioning only for limited hours.

A new document assessing 13 options for the future of hospital services in Chorley and Preston was published on August 22, but while it claims to be "clinically led" it notes (pages 9-10) that its preferred options have been precluded by a lack of capital and the financial plight of the trust which ended last financial year £46m in the red.

The report concludes it's not "clinically viable" to retain accident and emergency facilities at Chorley: but "It is clear from high-level clinical activity modelling that the population health requirements could not be serviced by one of the two current hospitals" – and there is no money to build a new hospital or expand either to cope.

Of the 13 options only one, Option 3, includes reopening services which have already been closed at Chorley - emergency surgery, inpatient paediatrics services or obstetric-led services: it's clear that this is not the favoured option, and others continue the downgrade of the hospital. The report warns:

"As a programme, we recognise that some of the options described in this paper may be difficult for some people to accept. The changes proposed will be difficult, but it is necessary to resolve the issues that we described in our Case for Change."

The cutbacks at Chorley have had knock-on effects on surrounding hospitals as far away as Bolton. Earlier this year Preston Hospital consultants, part of the same Lancashire Teaching Hospitals Foundation Trust as Chorley, wrote to trust executives and used social media to raise concerns about its struggling emergency services, which have been among the worst performing in England against the four-hour target.

Hinchingbrooke

In **Cambridgeshire** the first steps towards downgrading A&E services at **Hinchingbrooke Hospital,** which has been merged with Peterborough 24 miles

away into the North West Anglia Foundation Trust, have begun – despite repeated categorical assurances during the merger in 2017 that services would remain on existing sites, and that merger was the only way of maintaining A&E at Hinchingbrooke.

The financially-challenged Cambridgeshire & Peterborough STP is now proposing to close all trauma services at Hinchingbrooke, forcing patients to travel either to Peterborough or Addenbrooke's hospital in Cambridge, 23 miles way. This removes a key component of the A&E service, and will strengthen local concerns that it could be further downgraded, using the pretext of staff shortages.

Cheltenham

West County ITV reported at the beginning of August that **"Plans to close Cheltenham's A&E department"** had been confirmed by the town's MP.

Conservative MP Alex Chalk warned that the proposals would downgrade the accident and emergency department to an Urgent Treatment Centre, and set up a petition against the changes. He said that it was a "bad proposal" and "a flawed way of engaging about it".

Three days later, after the level of public anger became obvious, and as the political situation made an impending election more likely, ITV announced what appears to be simply a temporary reprieve: "Safe for now? Plans to close Cheltenham Hospital's A&E service have been delayed".

This has to make us wonder about political strings being pulled: how long will the reprieve last? and how many more downgrades are waiting in the wings?

West Midlands Ambulance loses contract

CCG ditches top quality patient transport service

Samantha Wathen, Press Officer and writer for Keep Our NHS Public

West Midlands Ambulance Service has been passed over in favour of private company E-zec to deliver non-emergency patient transport in Worcestershire, putting 80 jobs at risk, in a contract the WMAS Trust has held for 30 years.

This decision, one of a long and inglorious line of decisions by CCGs across England to privatise PTS services, with frequently disastrous results, has raised suspicion that it is nothing to do with performance, and everything to do with cost.

WMAS was the first ambulance trust ever to receive an 'outstanding' rating from the CQC, and this has just been confirmed for another year. The problem was that this quality service is more expensive than a poorer service. WMAS non-emergency service operations delivery director Michelle Brotherton said:

"We acknowledge that our bid fell outside the financial envelope set by the Commissioners, but we are simply not prepared to put patient care at risk."

Speaking to the BBC she added: "we know.... we would be unable to deliver a safe service and ensuring that we were meeting all of our performance targets within the financial cap that was put on the contract."

E-zec has not confirmed if it will keep the patient transport service based at stations in Kidderminster, Bromsgrove and Worcester. UNISON's regional organiser Chanel Willis said:

"We are all deeply shocked at the decision to award the contract to a private company. Many questions have yet to be answered – primarily where staff will be based. Staff have been in tears since the announcement and are devastated that the decision may affect patient care and their livelihoods."

Justifying the decision, a spokesperson for Herefordshire and Worcestershire CCGs said:

"The procurement process was robust to ensure the new NEPTS provider is able to deliver against the contract's quality and performance requirements. The process was weighted on patient quality and safety over financial considerations."

As The Lowdown reported earlier, since June 1 E-zec has also been responsible for providing non-emergency patient transport in BaNES, Swindon and Wiltshire (a 10-year contract worth around £80m) with the CCG publicly giving the same assurances over a robust procurement process.

However, the response to a recent Freedom of Information request submitted to Swindon CCG by the Swindon branch of Keep Our NHS Public suggests the motivation for their decision making was primarily based on cost:

"CCGs undertook a robust and legally-compliant competitive tendering procurement process...E-zec was awarded the contract on the basis of having the most economically advantageous tender"

Last year, the Care Quality Commission criticised the E-zec service in Bristol saying there was no evidence staff references had been received or reviewed, staff were not trained to carry out driving duties safely, bosses were unable to say if mandatory training had been completed and key targets were not always achieved.

In Swindon the previous provider, Arriva were not retained due to poor performance so subsequent due diligence processes should have been especially rigorous.

However, even a cursory Google search of E-zec reveals an alarming number of what appear to be damning reviews from both staff and patients, some of which include allegations of unsafe driving poor cleanliness and a bullying culture amongst workers.

In reality it is therefore debatable just how rigorous the checking process was, or indeed how high the bar is set on previous performance.

A second FOI submitted by Swindon KONP in July asked for details of patient complaints since the beginning of the contract in June. The answer revealed transport had failed to turn up for an end of life patient, whilst another palliative patient was wrongly refused the service.

E-zec currently holds 11 NHS contracts with various clinical commissioning groups and NHS Trusts across the UK. In Suffolk the company had missed three of its four performance targets every month this year up to March (when the most recent data was released)

When accused of putting cost-saving before quality CCGs have said there is little option available to them when budgets are tight.

A Swindon KONP spokesperson summed up campaigners' views, stating: "E-zec's performance to date provides a perfect example of why inept profit-making companies should not be running NHS services, and CCGs should not be enabling them."

E-zec has not confirmed if it will keep the patient transport service based at stations in Kidderminster, Bromsgrove and Worcester

Johnson 'cash-bombs' the electorate – with fictional NHS funding increases

John Lister

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In the month since our last issue was published we have seen the appointment of Boris Johnson as Prime Minister after a vote by Tory Party members, and the formation of a new cabinet composed only of ministers willing to toe the Johnson line, whatever that might be. Among them is Health and Social Care Secretary Matt Hancock.

There has also been a change in advisors shaping the decisions of the new PM, chief among them being Dominic Cummings, who orchestrated the Vote Leave referendum campaign. Johnson's health advisor is former McKinsey man Will Warr, who has little if any background in health, but nonetheless argues "more money is not the solution" to transforming the "hopelessly ill-equipped" NHS from "the monolith we have today," and is even more fanatical than Matt Hancock about the use of technology and apps to replace health care as we know it.

Soon after selecting his cabinet Johnson began making announcements about the NHS which have proved to be misleading. In early August news media trumpeted the story that he had "announced a one-off cash boost of £1.8 billion for NHS hospitals in England – about a tenth of the extra £350m a week the Leave campaign and the famous bus promised would flow to the NHS after Brexit.

The BBC and others loyally repeated the government claims that this was "money coming from the Treasury, and is not a reallocation of funds from the Department of Health".

The *Sunday Times* more accurately described the purpose behind Johnson's new policy as seeking to win electoral support, headlining "Boris Johnson drops £2bn NHS 'cash bomb' to woo female voters."

But within hours this story started to unravel: just £850m could be claimed to be extra spending, and this is far less than the billions that have been squeezed out of hospital budgets in so-called savings in recent years.

The day after Johnson's announcement, Nuffield Trust analyst Sally Gainsbury, who had immediately questioned the "new money" on Twitter, explained in the Guardian how the better-placed trusts had been persuaded to cut back on spending and run surpluses to help cover deficits elsewhere, and promised this would mean they could spend extra money on capital investment:

"Then came the catch. The Department of Health was happy to bank the trust efficiency savings …. But when it came to trusts actually spending the cash they had earned through the scheme, the department realised it would bump into the Treasury's cap on investment spending."

As recently as July NHS England wrote to trusts demanding further cuts, reducing their capital spending plans for this year by 20% – equivalent to about £1bn.

As a result, Gainsbury argues: "For this year at least, what the prime minister's announcement really means is simply reversing the broken promise made to trusts when they cut their costs in return for cash they were told they could spend."

Within hours the story started to unravel: just £850m could be claimed to be extra spending – far less than the billions that have been squeezed out of hospital budgets in so-called savings

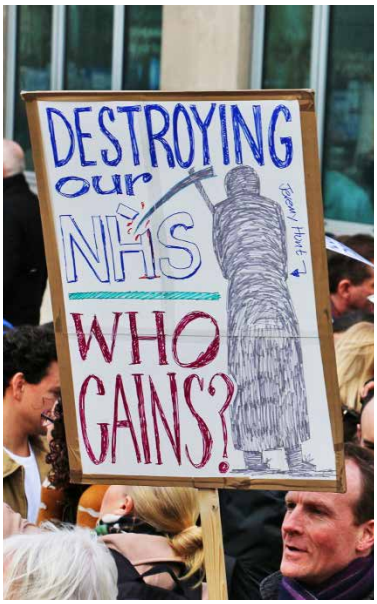
That same day Chris Hopson, the chief executive of NHS Providers, the membership organisation for NHS trusts, agreed that health think tanks were partly right to argue more than half of the money was not new: "some of the extra 2019-20 capital expenditure enabled by this announcement will be funded through cash surpluses currently sitting on provider balance sheets. That spending can legitimately be described as money that trusts already had, but were told they couldn't spend and are now able to spend."

Whether or not the money is new, it's also only a fraction of what it would really cost to upgrade 20 hospitals, according to Nuffield Trust boss Nigel Edwards, who described the money as "a welcome down payment on the staggering £6 billion needed to clear the backlog of NHS maintenance."

The scale of the problem is underlined by the news as this article is written that two NHS trusts have had to close 170 beds, and in one case ensure hourly fire inspections because of unresolved fire safety issues requiring capital spending.

Shadow Health Secretary Jonathan Ashworth was not only critical of the amount on offer but sceptical, pointing out that since 2017, 145 new spending schemes for hospital beds, buildings, medical equipment and information technology have been announced, totalling £2.5bn: but only 3 percent (less than £100m) of these schemes had actually been delivered. 'We will see if this money is ever delivered.'

Anita Charlesworth of the Health Foundation criticised Johnson's approach from a different angle, arguing that "the NHS urgently needs money to upgrade facilities. But capital investment must be driven by what patients need, and as part of a coherent strategy — not piecemeal announcements that make good headlines."



With debate still raging over the bigger announcement, Johnson followed up with another swiftly discredited, but much smaller promise, of an "extra" £25m for hospices on August 20, which was shown the next day by the HSJ not to be new money at all.

Three days later Johnson was again keen to cash in on the NHS as a vote-winner, making sure pictures of him with celebrity chef Prue Leith were linked with the re-announcement of the review of hospital food that had been set rolling by Matt Hancock in June after patients died of listeria after eating infected sandwiches. Johnson further alarmed cardiologists with the suggestion of feeding patients "hot buttered toast".

The Daily Mail swiftly afterwards revealed that Leith's son Danny Kruger is Johnson's secretary and fixer in Downing Street, while other news media looked back at the £50m-plus wasted on various previous headline-grabbing efforts to enlist celebrity chefs to help improve hospital food, all of which have foundered on chronically low funding per meal and the lack of hospital kitchens.

So if we can't trust Johnson to speak the truth on relatively small sums of money or deal seriously with problems of hospital catering, can we rely on his commitment, or those of his ministers not to include the NHS in trade talks with the USA after Brexit?

And what does his henchman Jacob Rees Mogg mean when he says on Radio 4 that the government will "bring forward legislation on the NHS"?

Bradford strikes force a pause ...

Support staff fighting Bradford Hospitals trust plans to hive them off to a "wholly owned company" have paused what would have been indefinite strike action.

In last minute talks brokered by ACAS, the Hospital Trust has agreed not to proceed with its plans to transfer all staff out of the NHS on October 1.

UNISON has instead been given the right to address the whole management board on September 12, and the Board will respond to UNISON by the end of the month. If they decide to continue with their plans, the earliest they can now proceed will be February 2020.

After three weeks of action so far, many staff are facing financial hardship, and they are still in need of funds. Donations to the crowd-funding appeal can be made online.

CQC forces closure of mental health unit

Child and adolescent mental health services in a North East Foundation Trust where two girls died in two months have been closed as the result of enforcement action by the Care Quality Commission.

The service is comprised of five units across West Lane Hospital, West Park Hospital and Roseberry Park. The units at West Lane Hospital in Middlesbrough have been closed, and 32 young people have had to be shipped to other units, which are likely to be crowded and further from their homes.

The CQC's enforcement action followed on concerns raised by inspectors at the trust in June 2019, which were confirmed by a return inspection on August 20 and 21, although the report identifying the most recent findings has not yet been published and will appear "in due course".

The June report, which the CQC says was "prompted by concerns raised about the treatment of young people receiving support, low staffing, a poor culture and a significant number of self-harming incidents at West Lane Hospital" noted a marked deterioration in services that had been rated Good overall, and Good for safe, effective, caring and well-led services only a year previously.

This time child and adolescent mental health wards were rated Inadequate overall and for safe, responsive and well-led services, and Requires Improvement for caring and effective services.

The CQC noted a marked deterioration in services that had been rated 'Good' overall only a year previously

Staff told the CQC that staffing was insufficient to support the complex needs of the young people using the service.

There have also been allegations of staff ill-treating patients, and using inappropriate techniques for moving patients. Middlesbrough Labour MP Andy McDonald told the BBC that the CQC action was evidence of a systemic failure.

Meanwhile the lack of government commitment to address desperate lack of resources in child and adolescent mental health is illustrated by a recent press release trumpeting the relatively trivial allocation of £3.3m across local projects to help prevent mental illness in children and young people.

The Local Government Association has called for a complete overhaul of children's mental health services to ensure young people receive better care and support.

The LGA is calling for more government funding and resources to ensure early diagnosis for children.

The councils argue that councils have had to use their own reduced budgets to pay for services to plug the gap to get young people the urgent treatment they require, while fragmentation and in the system forces young people and their families into a complex struggle with multiple practitioners and agencies.

IEA: a well-connected right wing think tank, paid to reject the NHS model

John Lister

Few weeks go by on the broadcast media's main "news" programme without an intervention from at least one spokesperson from the "Institute for Economic Affairs". However not one of the interviewers ever bothers to press the question of exactly who they are, and who funds them and their rabid neoliberal views, which include rejection of the NHS as a publicly funded and provided service, and opposition to the "sugar tax" and any attempt to combat the obesity epidemic by curbing the "freedoms of the giant food monopolies.

The IEA is technically is an "educational charity," but in practice operates as a consistently right wing think tank. It was founded in 1955, and according to Margaret Thatcher after her election in 1979 it "created the climate of opinion which made our victory possible".

As a reservoir of neoliberal ideology one of its natural targets for attack is the NHS, which the IEA dismisses as "one of the most overrated, inefficient systems in the world". Its ferocious promotion of a hard Brexit led to an IEA report being sharply criticised earlier this year by the Charity Commission for its obvious bias, given the organisation's status as a charity.

IEA has consistently refused to divulge any details of its funding, despite strong suspicions that much of it comes from overseas.

However recent research for the BMJ revealed that a significant sum comes from the tobacco industry:

"the organisation is part funded by British American Tobacco. In the past it has also taken money from the gambling, alcohol, sugar, and soft drink industries."

As recompense for this financial support, the IEA has stridently opposed public health measures for tackling smoking, obesity and harmful drinking.

Its website admits to annual income of £1.9m, and says it has between 11 and 50 staff. The only detail it has given on its funding is to admit in 2017 "its income of £2m came primarily from unnamed "foundations and trusts" (23%), "large businesses" (23%), and "individuals, entrepreneurs and family firms" (20%)."

The BMJ investigation includes an infographic plotting the IEA's financial links to 32 Tory MPs, and argues that the MP most closely and publicly associated ideologically with the IEA is one-time Tory leadership candidate Dominic Raab.

The BMA study also reminds us that although he "does not have direct links with the IEA", health secretary (and another failed Tory leadership candidate) Matt Hancock has in recent years received funding [totalling £32,000] from Neil Record, who became chair of the IEA board of trustees in 2015.

The IEA is also well-enough connected to secure ready and frequent access to national media coverage, especially through the many well-placed right wing editors at the BBC, while those with opposing views to the IEA seldom get a look in. Its young American associate director Kate Andrews has become a regular interviewee or participant in various news-based outlets, especially the BBC.

A professional 2-minute video of Andrews summing up the IEA's view that after 70 years "It's time to overhaul the NHS and replace it with a system fit for 2018" was produced by Newsnight.

Essentially the IEA rejects the basic structure and values of the NHS, and advocate insurance-based models. Their criticism of the NHS basically always reiterates the same points, so it's worth examining the accuracy and relevance of the claims made.

Andrews always works to the same basic list of countries whose systems she points to as more effective and preferable to the British NHS. The list includes Australia, Belgium, Netherlands, Germany and Switzerland.

All of these countries spend much more money per head of population than the UK. According to the latest OECD figures, **Australia** spends 12% more per head; **Belgium** (never cited by anyone other than the IEA as a model health care system) spends 15% more; **Netherlands** 28% more, **Germany** 32% more and **Switzerland** – one of the highest spending countries after the USA – 89% more per head than the UK. And of course the UK average is higher than spending in England.

Significantly increased levels of spending facilitate increased investment in staff, and in diagnostic equipment. The UK also has **less than half the OECD average provision** of MRI scanners, and **less than a third of the OECD average of CT scanners** (only Hungary and Mexico have lower provision). These are key in early detection and treatment of cancer; but a common criticism of the NHS by the IEA and similar organisations is that other countries outperform us on treatment of cancer.

Another factor in our lower spending is the low level of provision of nurses and doctors, where the UK is well below all of the IEA's chosen comparisons. Our provision of hospital beds is 4th from the bottom of all the OECD countries. This same point has been widely raised, for example by a recent Nuffield Trust report.

The IEA dismisses and ignores the US-based Commonwealth Fund's comparison of 11 different health care systems, which has consistently ranked the UK as the best overall performer despite the relatively limited spending. Belgium is not included in their comparison, Australia comes second to Britain, Netherlands third, Switzerland sixth and Germany eighth.

The Commonwealth Fund study, which also has significant weaknesses, is based on five key measures – Care Process, Access, Administrative Efficiency, Equity and Health Care Outcomes. The UK comes third on access and efficiency, tenth on outcomes, but top on care process and equity – largely because of the way in which it has been structured without up-front charges for care.

These issues are of no concern to the IEA. While it claims its favoured models give "universal access", its preferred systems are all very different, highly complex social insurance systems with much higher levels of charges for treatment.

"the organisation is part funded by British American Tobacco. In the past it has also taken money from the gambling, alcohol, sugar, and soft drink industries."

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Switzerland is one of the wealthiest countries in Europe, yet the proportion of private 'out of pocket' spending on health is exceptionally high at 26% of total health spending. This means that low and middle income households pay a higher proportion of their income for health care than the richest.

Swiss patients wanting health care have to pay a "deductible" (fixed amount to be paid before insurance cover begins to reimburse costs) as well as a copayment (a percentage of the cost of treatment) which cannot by law be covered by insurance.

There is a £12 per day fee for hospital inpatient treatment. Mandatory health insurance does not cover 90% of dental costs, or some outpatient treatment such as psychotherapy.

Far from giving the same coverage or better than the NHS, the Swiss system is more expensive for individuals and much more unequal.

In **Germany** health budgets are controlled by an immense bureaucracy of 132 different "sickness funds:" but the system is not a universal one covering all citizens. There is a separate system of insurance for the highest paid (earning above €4,050 per month). These people with above average wealth also tend to have above average good health.

Separating them out so they do not contribute to the costs of health care of those on lower incomes, allows them to pay lower contributions, despite entitlement to higher benefits. This means that the population with least means and highest risk of ill health are left in a separate system. This is very different from the British system based on progressive taxation.

The IEA is very keen on the **Belgian** system, but the whole Belgian population, 10.7 million, is not much bigger than London. However one very striking difference is that the Belgian health budget is fixed by legislation which requires it to grow in real terms each year.

If this applied to the UK, our health spending would already be significantly higher, after 9 years of austerity levels of funding. Belgium also has far higher costs to individual patients than the British NHS.

The **Australian** government subsidises private health insurance, spending $6 billion every year to give tax breaks to those with insurance, even though private treatment costs are notoriously inflated and the same money could open far more public sector hospitals and improve the service to all. As in so many countries it's the publicly-funded hospitals that carry most of the burden of emergency and complex care.

The **Netherlands** system scores highly in many comparative studies, but it is one of the most expensive, seventh largest spend per head. The complex combination of mandatory and voluntary health insurance also means that costs fall disproportionately on low and lower-middle income individuals, who end up paying between 20-25% of their income in healthcare costs: this is far less equitable than the UK system. Competition has increased the bureaucratization of the healthcare system, with over 1400 different insurance packages, making choice for consumers extremely complicated.

More recently the IEA has begun to throw in some completely different examples, such as Hong Kong and Singapore, which again are very different systems for small populations.

Hong Kong has a population of 7.3 million – less than London – and a health care system that is funded from general taxation – but at a rate of 6.1% of GDP (just over £2,000 per person), so the health budget does not cover all of the costs of the service. As a result there are user fees for hospital care, including emergency care. In addition the under-funding and inadequate provision of hospital care means there are long waiting times for treatment, with delays of up to 20 hours for emergency admissions, from 36 to 110 months wait for a joint replacement, and a six month wait for outpatients – much worse than the NHS. There is a developed private hospital network, but the charges are prohibitive for the poorest.

Singapore is an authoritarian city-state, with an even smaller population (5.6 million), and spends just 3% of its GDP on health. It does not offer universal or comprehensive health coverage: unlike the NHS, services are only subsidised from general taxation, and subject to means tested charges, with no annual cap on out of pocket spending.

Hospitals advertise their charges so that patients can decide whether or not they can afford to access treatment. In 2013 more than two thirds (69%) of Singapore's health spending was private spending, and the vast majority of this (88%) was out of pocket spending by individuals, the most regressive way to pay for health care.

Copayments, deductibles, and restrictions on the uses of health insurance schemes (Medisave and MediShield) to cover costs of consultations, treatments, and procedures are all designed to discourage unnecessary doctor visits, tests, and treatments and keep health care "demand" in check. However each of these has greatest impact on people on the lowest incomes who are also most likely to suffer illness and need health care.

So it's clear the IEA consistently favours high cost, insurance-based schemes with significant spending on bureaucracy.

They pay no regard to the impact of user fees on the poorest, and seem unconcerned with the need for universal or comprehensive services.

Perhaps most important, they are quite happy to criticise poor outcomes from the British system without discussing the very substantial additional cost – to government and to individuals and their families, especially those who would face hefty charges – of changing over to any of the IEA's preferred models.

What the (research) papers say

JOHN LISTER looks at three recent academic papers and a book relevant to NHS campaigners

Health inequalities – don't forget the politics!

The importance of action to address the causes ("social determinants) of ill health and improve public health as part of any plan to improve and expand the NHS is widely accepted in words, and a crucial assumption of the NHS Long Term Plan in England, so any books or articles that remind us of the health consequences of austerity and inequality must be welcomed.

This summer has seen not only another interesting free access article demonstrating the impact of financial crisis and austerity on health in Andalusia, but also open access to an entire 290-page book on Health in Hard Times, focused on the British context and in particular the north east of England.

Both make important points and remind us of some of the long term effects of austerity as a policy option implemented by governments. But both also have surprising weaknesses.

The study on Andalusia, the large southern region of the Spanish state that suffered especially brutal repression under General Franco's fascist rule published in the *International Journal for Equity in Health*, notes that it was one of the regions most damaged by the economic crisis triggered from 2008 by the banking crisis.

The impact was exacerbated by the subsequent brutal austerity regime imposed on Spain, as well as Ireland, Portugal, and most infamously Greece by the "troika" of the European Commission, the European Central Bank and the International Monetary Fund.

Andalusia faced a much heavier reduction in health budget than other regions of the Spanish state (13.9% compared with an average of 9%) as well as closure of several services, loss of hospital beds, the axing of over 7,000 health care jobs, the imposition of co-payments for prescriptions for pensioners and those on high-incomes, and changes to the health care system to make coverage dependent on social security contributions, ending NHS-style entitlement based on residency.

Waiting lists for treatment have grown, the quality of care has fallen, primary care and prevention have been cut back – at a time when falling living standards and growing unemployment was also undermining public health. The study reports on interviews in which people from different social layers – the poorest and most vulnerable, the middle class and "upper social class" express their experience and reaction to the changes that have taken place.

For the poorest, the focus is much more on survival: access to a basic diet and their ability to afford medicines, especially for children. For the middle class the preoccupation is much more focused on mental health, the increased pressures, and the lack of resources in health care.

Andalusia lost 13.9% of its health budget compared with a Spanish average of 9%, and over 7,000 health care jobs

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By contrast the wealthiest groups "did not consider that the crisis had directly affected their health, yet they were very aware of how it had impacted Andalusian society in general."

Missing from this interesting account is any mention of one of the more discriminated against and vulnerable communities in Andalusia, the marginalised Gypsy population whose limited access to education and employment increases their need for assistance from the State health service – or indeed any discussion of ethnic minorities.

Nor, in a region which in January saw an end to 36 years of socialist control and the establishment of a new right wing government propped up by the far right, is there any discussion of the ways in which regional government action might have addressed some of the problems, or now make them even worse by further cutting taxes (and thus government revenue), further reducing welfare benefits and support for disabled people, and further increasing levels of discrimination.

Similar weaknesses also spring out from the new book Health in Hard Times, even though its Foreword promises to provide "a vivid illustration of how health inequalities are largely the result of political choices."

The book is edited by Clare Bambra, Professor of Public Health at Newcastle University, who summarises it on Twitter as demonstrating "the impact of austerity on health inequalities using mixed methods research". It seeks to go beyond limited analysis of inequalities based either on the composition of the local population or the specifics of the geographical context to bring in political-economic factors and a historical view. In doing so it offers a wide range of useful and alarming information, identifying the impact of key measures (p13).

The book is primarily focused on just one north east town, Stockton on Tees. We learn that there is a staggering 15-year gap in life expectancy between the most and least deprived areas of the town, which are just two miles apart. Stockton in this respect is typical of some of the more deprived areas of the north of England, where as one new campaign has pointed out "over half of the North has a lower life expectancy than the worst area in the South."

But in other ways Stockton is very untypical. In particular, along with much of the north east it has very low proportion of non-white residents: ONS figures show that it has less than half the English average of Asian and British Asian population, around a quarter of the English average of Black or Black British, almost 10% fewer non-white people. The book's focus on this one town means that scant attention is paid to the health impact of health inequalities and racial discrimination on ethnic minorities.

A focus on just one town also serves to understate the scale of the problem, which is especially acute in Britain, but a wider issue across Europe: "European Union-level analysis suggested that the costs of health inequalities amounted to EUR 980 billion per year, or 9.4% of gross domestic product (GDP) – as a result of lost productivity and health care and welfare costs.

"… Analysis has also suggested that increasing the health of the lowest 50% of the European population to the average health of the top 50% would improve labour productivity by 1.4% of GDP each year – meaning that within five years of these improvements, GDP would be more than 7% higher." (p247).

However this also highlights an elephant in the room which the entire book ignores: despite Stockton's massive vote to leave the EU, along with much of the north east, the word Brexit appears only once in 290 pages, and the issues it poses are not addressed at all – even in a book published in June 2019, amid mounting public and media concern over the dangers of a no-deal Brexit.

The likely post-Brexit recession would impact very heavily on the economy of the Brexit-voting north east and therefore once again on the health of its people.

And despite repeated reference to political economy, there is very little explicitly political assessment, even though it's clear that action on any scale sufficient to address health inequalities requires a full scale change of government and policy – from actively making things worse since 2010, to seeking to address problems that have been created.

Clare Bambra and colleagues know it is not an accident that levels of child poverty and homelessness have increased since 2010, and are far worse overall in the north than the south. The book states several times that austerity policies are a choice and not an inevitability. But it pulls its punches.

The book states several times that austerity policies are a choice and not an inevitability.

The lack of any current political analysis and the silence on Brexit underline the fact that, with the partial exception of Clare Bambra's concluding chapter, much of the book also reads as already seriously out of date, although this is possibly a result of publication delays rather than all of the chapters coming from academics.

Much of the information in the edited chapters that make up the majority of the book appears to rely on relatively dated references, not least a useful list of reactionary "welfare reforms" from 2010, which sadly ends prematurely in 2015 (p14).

However the book gives useful information, it's well-researched, and it's free to access.

Hospital chez vous?

"Hospital at home" (HAH), like mergers and reconfiguration, is a concept that is often trotted out by NHS bosses in England, although they tend to be stronger on the long term promise than on the actual delivery of services.

Few NHS commissioners or providers pay much attention to the aspect of "hospital at home" that has been investigated by another free access paper in The experience of patients and family caregivers during hospital-at-home in France.

It shows that HAH is already established as a significant factor in French health care:

"HAH is a model of care that provides acute-level services in the patient home and can also in some cases be set up in a nursing home. HAH is a less expensive way than conventional hospitalization with an average cost of 198€/day in the French health system."

41% of French HAH providers are public sector, 41% non-profit, and the remainder is provided by profit-seeking companies. HAH accounted for 4.6% of the total of bed days in France with payments totalling €913 million to 308 HAH institutions in 2015.

Can we, ethically, favour patient's well-being over caregiver's suffering?

The study uses interviews with patients and caregivers, all in the Paris area. It found that "HAH remains widely unknown among patients and caregivers, who rarely are at the origin of the admission, and lack information before the return home."

It reveals some of the stresses and strains on caregivers, pointing out that the extra work could lead to a real deterioration of their relationship, but also of the caregiver's health. The study raises a "fundamental" question that needs to be asked of the NHS:

"Can we, ethically, favour patient's well-being over caregiver's suffering? If HAH is beneficial to patients but strongly impacts caregivers, should we deprive the patient from a better care to relieve the caregiver? Or should we force the caregiver to bear the situation in the name of "good care"?"

Nordic health emergency

Another free access paper giving an interesting sidelight on problems we face in England comes from Norway. Emergency department crowding and length of stay before and after an increased catchment area takes a familiar story: the merger of four hospitals on the outskirts of Oslo to form Oslo University Hospital, followed by closure of some of the previous capacity, including (unlike England) closing a University Hospital (Aker).

About 150,000 inhabitants which had Aker as their local hospital, were transferred to Akershus University Hospital, now the biggest emergency department in Norway.

"Thus, the catchment area of Akershus University Hospital increased by 44% from Jan 1st 2011, from 340,000 to 490,000, the latter approximately 10% of the Norwegian population." The hospital had already, been struggling with bed capacity, with a high bed occupancy level.

The study reminds us NHS commissioners and their management consultants do not have a monopoly on half-baked plans. In Norway, too, inadequate resources lead to delays: length of stay (LOS) increased by 20.9% as admissions increased by 41%, with neurology admissions up 46.5%.

"Even after 5 years, the LOS was higher than before the expansion, mainly because of the throughput and output components, which were not properly adapted to the changes in input."

Even in wealthy Norway: "The increased catchment area … aimed to reduce costs and increase quality." However "Increased LOS and crowding is often a sign of the opposite, as a longer stay in the ED increases the risk of adverse events and decrease patient safety."

THE lowdown

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