THE lowdown

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

Fresh bid to force repeal of Health and Social Care Act

Shadow Health Secretary Jonathan Ashworth broke with convention last week by challenging the Queen's Speech: he tabled an amendment regretting that it did not commit to repeal the Health and Social Care Act.

This was aimed at puncturing the Johnson government's efforts to portray thmselves as supporters of the NHS: but it was also a timely reminder that until it is repealed the Act remains the legal basis of the NHS.

Attempts by NHS England to get around the Act's limitations have led to the establishment of an increasing proliferation of undemocratic and unaccountable organisations with no legal powers or legitimate status, notably Sustainability and Transformation Partnerships and "Integrated Care Systems".

But there is little point in merely tinkering with details: the Act itself, the regulations attached to it, and the legislation it amended in the 2006 Act to create a competitive market in health care, all stand in the way of progress.

The repeal is needed to:

- reinstate and strengthen the responsibility of the Secretary of State to provide a comprehensive and universal health care system,
- end the focus on competition and the requirement on commissioning bodies to put services out to competitive tender,
- begin to unravel the contracts which have opened up mental health, community health, primary care and other clinical services as well as support services to private providers,
- and legislate to exclude the NHS and all its services from the provisions of the European Union's Public Procurement Directive and from the Public Contract Regulations 2015.

Attempts by NHS England to get around the Act's limitations have led to an increasing proliferation of undemocratic and unaccountable organisations

Only by legislating in this way to reverse the privatisation process of the last 20 years and reintegrate the NHS as a public service can we protect it from the impact of future trade deals with the US and other countries, and ensure patient data is used only for the improvement of health services and not sold off or exploited for commercial gain.

After a delay while Johnson attempted to steamrolller his 100-page Brexit bill through in a breakneck 3 days, Ashworth's challenge was debated on October 23, but the amendment was defeated – with the Lib Dems abstaining to give ministers an easy ride.

Fragmentation and broken promises - a look back at the Act that was pushed through by Tories and Lib Dems - p4-5

Compass strikers pay protest at Surrey HQ

The need to halt and reverse privatisation was underlined by the continued fight by support staff employed by contractor Compass at NHS trusts in St Helens and Blackpool.

They have taken 12 days of strike action, challenging the company's refusal to match NHS pay rates and working conditions.

On October 22 a coachload of striking Compass workers travelled to the company's Chertsey headquarters (see above) to urge their employer to pay them the same as their NHS colleagues.

Most Compass employees are on the minimum wage (£8.21 an hour), yet work alongside staff employed directly by the NHS, where the lowest hourly rate is £9.03. This difference of 82p an hour is worth around £1,500 a year.

IN THIS ISSUE

Saving our NHS: staff tell us the truth that ministers won't

Truth is a casualty in every election, but this time more than ever the NHS cannot afford for its situation to be misrepresented. It is in a hole, beleaguered by a decade of harmful health policy and it needs a clear escape plan that the public can support. PAUL EVANS explains.

Recently I heard a hospital medic speak about a colleague's experience as a junior doctor, on call, at night covering 5 wards, about 100 patients.

A male cancer patient was under treatment and doing well, the consultant had noticed an infection, picked up whilst he was undergoing chemotherapy and so a round of antibiotics was urgently prescribed.

The junior doctor saw the instruction but for whatever reason didn't tick the box for immediate treatment on the computer system.

Normally this would be picked up by the nursing staff, but on this occasion the ward was understaffed and by nurses who don't normally work on a specialist cancer ward.

This vital few hours delay meant that her patients condition worsened, he was transferred to intensive care but tragically he died a few hours later.

An avoidable death, a mistake by an over worked doctor, but also a failure of system working too close to the edge.

Country-wide problem

We know from multiple reports and surveys that a lack of staff is compromising care right across the NHS. The health watchdog (CQC) has found that 70% of hospital trusts in England are failing to meet national safety standards.

One junior doctor told the *Guardian* last year, "The youngest doctors in the hospital are given dangerous levels of responsibility; there is one newly qualified junior doctor to 400 patients on night shifts. The administration is in agreement, but confess there is not enough money to employ extra staff."

In a survey of NHS staff, which included nurses, doctors and managers 80% said they had raised concerns about unsafe staff levels. More than half said that no action had been taken.

NHS leaders say understaffing is their number one concern.

The health service is short of 100,000 staff - including 70,000 nurses and 7000 GPs, but analysts predict that this will rise to a deficit of 250,000 staff by 2020 if the NHS continues on the same trajectory.

Despite all the evidence and unified calls for action, the NHS still does not have a funding commitment that can boost its capacity, make it safer and push up the standards of care.

The staffing crisis has been fuelled by funding cuts of £2bn in the education and training of staff, since 2006. Overall health experts blame "an incoherent approach to workforce policy at a national level, poor workforce planning, restrictive immigration policies and inadequate funding for training places".

"Current performance levels are the worst in a decade and trying to work NHS staff harder and harder is simply not sustainable"

The *Interim NHS People Plan* – the new workforce strategy was only published by NHS England in June. Repeatedly delayed, it has finally arrived several years into the crisis. Despite receiving widespread approval for its dissection of the situation, it was not backed by any significant new money to bring about the sizeable uplift in staff training and recruitment that the NHS needs.

NHS leaders are frustrated, calling for a "funded, credible" workforce plan.

This month's *State of the NHS* report from NHS Providers concludes that "Current performance levels are the worst in a decade and trying to work NHS staff harder and harder is simply not sustainable"

Trade unions have been running long standing campaigns to introduce safe staffing levels and reintroduce the bursary for nursing students. Alongside the TUC, eight health unions are calling for a long-term commitment to properly fund the NHS - in line with the cost evidence presented to the government by the Institute for Fiscal Studies.

Nail the funding lie

Meanwhile ministers, without any shame tell us that the NHS has received "record investment" – presenting inadequate rises to an already insufficient budget as a reason for celebration.

In reality the NHS has suffered the longest and deepest period of underfunding in its history.

A 9-year funding squeeze has restricted the NHS to annual rises of 1.5% against rising costs of nearly 4% (2010-18).

Year by year the funding gap has grown. Trouble with balance sheets has inevitably translated into human suffering - cuts to services, understaffing, rationing, delays, compromised care and sometimes tragic failure.

Theresa May announced an extra £20bn over five years in 2018, which was recognised by economists as enough to keep the lights on (3.3% a year after inflation) but not the investment needed to improve standards (minimum of 4.1% per year).

In recent weeks Boris Johnson, keen to fix the Tories' slash and burn reputation has announced that he will spend an extra £1.8bn on upgrades for NHS hospitals, telling the BBC "I want to stress that this is new money".

Within a few hours an analysis by Sally Gainsbury, a policy analyst at the Nuffield trust, revealed that £1bn of the money was already in hospital accounts, as restricted savings. Mr Johnson was in effect just giving his permission to spend it.

The hyperbole around the building plans ballooned further out of control with Health Secretary Matt Hancock's extravagant claim to the Tory Party conference.

"Over the next decade we will build, not ten, not twenty, but forty new state of the art hospitals."

Alas again analysts exposed this exaggeration, but not before it was reported widely across the media.

Over the next 5 years the NHS will spend

an extra £3bn on capital projects, but the majority of the new money will go to just six trusts, each with hospitals in bad disrepair and whose projects are already in the pipeline.

A further 21 trusts will receive a small amount of seed-funding to "kick-start" their plans for the end of the next decade.

Cash strapped hospitals have built up a huge backlog of repairs estimated at £6bn. The Health Foundation predict that the NHS needs around £3bn every year for the next 5 years to get a grip on the problem.

Some areas of the NHS, like mental health and community services are getting a bigger uplift this year than the budget as a whole - as ministers will no doubt remind us, but only after several years of neglect and at a cost to other parts of the NHS as the overall size of the cake is just not bigger enough.

What does the NHS need?

Health economists agree that the government's funding pledges fall short because of one simple reality. They don't meet the inevitable and basic costs of the NHS: Growing numbers of older people, more chronic disease, new treatments and price inflation.

These are challenges which governments in many countries must confront. They mean that health budgets must rise by a minimum amount each year, just for standards to be maintained.

The NHS needs about 4% annual in terms just to meet current cost pressures and that's without raising the levels of care.

Ministers celebrated "the record investment" of an extra £20.5bn over five years and of course the NHS was relieved, but look at what it means year by year and the new level is still below the average annual increase that the NHS has received since it began, which is 3.7% (1948-2018).

The new NHS 10-year plan contains an ambitious wish list of improved care, which simply cannot be achieved without a realistic and long-term funding commitment which must be based upon the evidence about the costs the NHS faces.

Social Care and beyond

Of course, the pressures on the NHS are also linked strongly to the fate of other care services. Cuts to adult social care have reduced the number of people receiving these services by quarter. Health conditions are missed and left to worsen until finally people seek help from the ambulance services, GPs and their local A&E.

Emergency departments are often the place of last resort. Increasingly visible are the casualties of austerity; people who have become patients because of neglect, cuts to services and because they have no-where else to go.

Year by year the funding gap has grown. Trouble with balance sheets has inevitably translated into human suffering - cuts to services, understaffing, rationing, delays, compromised care and sometimes tragic failure

Listening to an A&E doctor speak at a public meeting recently, she described her most recent shift - a string of patients with complex needs:

An Elderly lady came in whose leg ulcers had become infected, because of neglect, she wasn't being cleaned properly.

She treated a young man with a deep wide cut on his face and he wouldn't say how he got it.

Two young women came in, one was a teenager and she had tried to commit suicide.

The other was an alcoholic and was getting withdrawal symptoms.

Two more of her patients were homeless.

The doctor pointed out that they all had access to healthcare but problems elsewhere in our society and in our care systems had led them to the NHS. The audience applauded loudly as she pointed out that we must do far more to address the causes of ill health - poverty, housing, family break up and addiction.

Policy questions

Almost 40 years ago the Black report concluded that health inequalities were due to many other social inequalities and recommended a wide strategy of social policy measures to combat the situation.

The report was rejected by the Secretary of State at the time and for decades ministers have been failing to confront the reality that these issues are connected and so must be our response.

So how does pressure on the NHS and its evident lack of capacity relate to the wider plans around the NHS? They are inextricably linked and we will be returning to this in Lowdown, as we do battle with our political leaders for an honest debate about what's happening in our NHS and what it needs to secure its future.

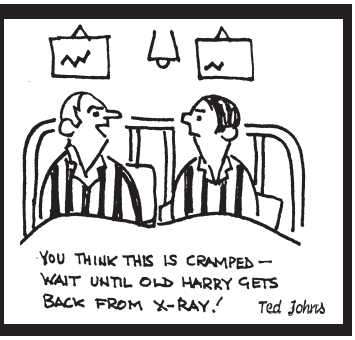
FACTS BEHIND A DECADE OF NEGLECT

Hospitals have built up a £6bn back log of repairs after their capital budgets have repeatedly been cut and the money used to cover running costs.

Key areas like public health are being cut - 25% less per head by 2020/21, when challenges like obesity related disease are costing the NHS over £6bn every year.

Despite recent announcements The NHS is enduring the biggest funding squeeze in its history – Over the decade average annual rises of 2.1% are too low to maintain standards. Economists agree that more than 4.1% a year is needed to improve them.

Social care spending has fallen by 5% in real terms since 2010/11. Even with recent increases, spending was around £1bn less than in 2010/11.



Why we need to scrap the Health & Social Care Act – and rescue our NHS

Many of today's campaigners have only dim memories – if that – of the Health and Social Care Act 2012 and how it was originally argued for by its author Andrew Lansley, and by leading Tory and Lib Dem politicians, in the teeth of opposition from almost every other party. So here JOHN LISTER looks back at the Act, the promises that were made and the grim results that show the need for its repeal.

The Health & Social Care Act (HSCA) 2012, which only affects England, was eventually pushed through parliament by the votes of Liberal Democrat MPs and peers supporting David Cameron's Conservatives.

The Bill's advocates made a series of misleading promises on how it would improve the NHS: instead, as its critics warned, it has made things worse. But now the HSCA is almost universally recognised to be not fit for purpose, with even NHS England pushing for parts of it to be repealed. Indeed the only argument against its repeal has been the claim that it would require another top-down reorganisation.

Six years of failure

The repeal of the 2012 Act is long overdue. Six long years since it came into force have proved beyond doubt that it cannot and will not deliver any of the promised benefits to patients or to NHS staff.

Government Fact Sheets explaining the basis for the Act in 2012 claimed it would deliver a number of improvements, among them:

"Clinically led commissioning; Provider regulation to support innovation; Greater voice for patients; New focus for public health; Greater accountability locally and nationally; Improved quality; Tackle inequalities; Promote integration; Choice and competition"

With the exception of competition, none of these has been delivered.

The promise that CCGs would be led by GPs, and that commissioning would therefore be "clinically led" was discredited before the CCGs had even been established in 2013: only a tiny handful of GPs, steered by management consultants, have ever involved themselves with CCGs. Far from being "clinically led" even the King's Fund in 2016 admitted that "financial pressures mean CCGs are frequently required to take tough prioritisation decisions," and others flow from the requirement to put services out to tender.

The "changes to provider regulation" were focused not on innovation but on scrapping the cap on the level of income foundation trusts could make from private medicine and commercial contracts. Amendments to the Bill resulted in the Act lifting the limit to less than half the FT's income – commonly interpreted as 49%.

There are around 1,140 beds in NHS private patient units in 90 hospitals: they generate income of £600m a year, although there are no published figures on how much these services cost to provide. Some major London foundation trusts such as the Royal Marsden make as much as 36% of income from private patients, but with no evidence that this benefits NHS patients.

By contrast the NHS has increased spending on sending patients for treatment in private hospitals to £1.8 billion a year – not least because of the lack of capacity after closure of 8,800 general and acute beds as a result of austerity funding since 2010.

The "greater voice of patients" and the commitment to "no decision about me without me" was an empty promise from the beginning, since CCGs have from the outset been at least as insensitive to public views and resistant to public consultation as previous PCTs and health authorities.

The problem is set to worsen as CCGs – with little or no consultation – merge into ever larger and more remote bodies, some of which aim to cover 2 million people.

Public health services have been run down, sidelined and even privatised by local and national government since the HSC Act, with year on year real terms cuts in central government funding running alongside the 40%-plus cutbacks in local government funding since 2010.

Since the 2012 Act there has been significantly LESS accountability locally and nationally, with increasing levels of contracting out of services on contracts jealously guarded as commercial secrets.

At national level NHS England is even now driving through a top-down reorganisation and outsourcing of imaging and pathology services with no proper local consultation, and ignoring local voices challenging their decisions.

Far from offering improved quality of services, the Act has done nothing to prevent a massive all-round drop in performance against previous targets – with increased waiting times for emergency and elective hospital care, 4.3 million on rising waiting lists, long delays to access mental health care, growing delays in primary care appointments, and missed targets for swift treatment of cancer.

Health inequalities, which the Act was supposed to address have widened to extreme levels with a 16 year gap in healthy life expectancy between the wealthiest and most deprived areas, greater than the difference between the UK and Sudan.

Growing lists of treatments of supposedly "low clinical value" – including hip replacements and cataract surgery are being excluded by CCGs and NHS trusts, creating a

Since the 2012 Act there has been significantly LESS account-ability locally and nationally, with increasing levels of contracting out of services

2-tier system in which only those wealthy enough to pay privately can access the care they need.

The empty promise that the Act would "promote integration" has been comprehensively discredited by the succession of measures subsequently taken by NHS England to sidestep the law in order to "integrate" services. Local government remains an under-funded and largely ignored subordinate "partner". And within the NHS itself the Act has served to DIS-integrate services as CCGs, obeying its regulations, have carved services up into contracts and put out to tender.

At the core of the Act was the promise of "choice and competition": but too many patients have seen their choice of local access to services overridden by cash-driven cuts and reconfiguration of trusts.

Meanwhile there is no evidence at all that competition has served to improve health services. This was clearly the view of the all-party Commons Health Committee in June this year, which noted that: "Competition rules add costs and complexities, without corresponding benefits for patients and taxpayers in return."

Indeed the disadvantages of a regime of contracting and competition arise whether or not the contract is awarded to a private bidder. Carving up services into thousands of separate contracts, and subjecting them to competition tends to force cost cutting and reduce the quality of care even if an NHS provider wins: and it also disintegrates services by awarding contracts to non-local providers.

However there have been numerous contract failures by private companies that have gone bust or abandoned contracts leaving patients and the NHS in the lurch: there have been no compensating benefits.

The record speaks for itself. The 2012 Act has dislocated and undermined services, reduced accountability to local communities, ignored patients' needs and concerns, further fragmented the NHS, obstructed efforts to secure collaboration between providers and between commissioners and providers, and opened up the danger of the £115 billion NHS budget being opened up to US and other corporations in future trade deals.

Anyone with any informed view has come to the conclusion that competition, contracting and market mechanisms have no benefit for health care systems and are an expensive encumbrance.

So the onus is on anyone who wants to keep this discredited and disreputable law in place to show what benefits it might offer to patients or hard-pressed NHS staff.

Campaigning postcard against the Act (2012)

'Not now' says the King's Fund: but when would change be right?

John Lister

King's Fund boss Richard Murray has continued in the inglorious steps of his predecessors in tail-ending government policy and rejecting any real challenge to the status quo, urging Labour not to press for a repeal of the Health & Social Care Act which the Fund itself conceded back in 2015 was "damaging".

Murray's defeatist blog argues that now is "not the right time" to deal with the legislation that has fragmented the NHS into thousands of contracts and privatised sections of it: "It is unwise to begin a re-fit of the NHS ocean liner in the midst of a hurricane."

So what could be the right time for bold action? How long does the King's Fund think it is right for the NHS to follow down a "damaging" path rather than attempt to secure a sound basis for longer term progress?

If it's not right to change course when the NHS is failing on so many targets, short of over 100,000 staff, deep in deficit and beset by crumbling buildings and clapped out equipment, when would it be right?

Murray's blog also ignores the potential imminent danger of the NHS being thrown into post-Brexit trade deals.

"Give it to us straight. How long have we got?"

Disruptive

He asserts it would be 'disruptive' for the NHS to face a new reorganisation: but few of the most important changes would disrupt the work of front line staff at all.

Five key issues must be addressed:

1. Restoring and clearly stating the duty of the Secretary of State to provide a comprehensive and universal health service.

This is not at all disruptive for front line staff, and can easily be achieved by legislation

2. Revoking and repealing all the regulations, clauses and sections of the 2012 Act that require local commissioners to put clinical and other services out to tender and made the NHS subject to competition law.

This is not controversial or disruptive. It reduces existing levels of disruption and disintegration, reassures NHS staff that they will not be forcibly transferred to a new employer, and reassures local people that services will be secure.

3. Beginning the process of rolling back the outsourcing and privatisation that has taken place, to reinstate a **publicly provided** NHS, in which all future services are governed by service level agreements rather than contracts and clearly excluded from public procurement regulations.

Contract failures

The case for this has been made by the repeated and widespread failures of private contracts: many managers will welcome it. Where it has been done, most notably in Wales, it has been shown to have beneficial impact on the quality of services and morale of staff.

4. Ending Foundation Trust status would **nullify the provisions of the Act** that encourage Foundation Trusts to generate increasing shares of their income from private medicine and private commercial activity.

This is disruptive only in the handful of FTs that have already expanded their private beds and services.

5. Establishing new, unified NHS bodies at local level that will bring together purchasers and providers in a single, publicly accountable NHS body. This will end the costly, wasteful and divisive purchaser/provider split instituted by Margaret Thatcher and entrenched by subsequent government "reforms" despite the lack of any evidence it has improved services or benefited patients.

This is also the area in which the 2012 Act created the greatest dislocation, with the scrapping of PCTs and establishment of CCGs.

However NHS England's Long Term Plan is already proposing to bring CCGs and trusts into so-called 'Integrated Care Systems': the disruption is already happening.

Under the current Act these bodies lack any democratic accountability or legal status: and without the changes listed above could be a step towards further privatisation.

New legislation is vital to ensure that integration is a process of rebuilding our NHS as a public service, publicly funded, provided and accountable.

Spike in heart attacks, asthma attacks and strokes on high air pollution days

New data shows that high air pollution days lead to a spike in the number of children and adults experiencing heart attacks or being sent to hospitals for strokes or severe asthma attacks. SYLVIA DAVIDSON reports.

King's College London, in conjunction with UK100, a network of local council leaders, has reported data for nine English cities which show that high air pollution days trigger an additional 124 out-of hospital cardiac arrests, 231 hospitalisations for stroke and 193 children and adults hospitalised for asthma.

The data was released to coincide with the International Clean Air Summit, held Wednesday 23 October by London mayor, Sadiq Khan and UK100, a network of local government leaders across England that have pledged to shift wholly to clean energy by 2050, with the World Health Organisation Director General, Tedros Adhanom.

Broken down, the data for the nine cities is as follows: London had 338 more emergencies a year on high pollution days compared with low pollution days, Birmingham (65 a year), Manchester (34), Liverpool (28), Bristol (22), Nottingham (19), Derby (16), Southampton (16) and Oxford (10).

Dr Heather Walton, Senior Lecturer in Environmental Health from King's College said: "The impact of air pollution on our health has been crucial in justifying air pollution reduction policies for some time, and mostly concentrates on effects connected to life-expectancy. However, health studies show clear links with a much wider range of health effects."

Previous studies have found a link between high air pollution days and a spike in visits to A&E and GPs and on life-expectancy, but this new data gives very precise figures for individual cities.

The data is a subset of material that will be published in an upcoming report, Personalising The Health Impacts of Air Pollution, due out in November 2019.

Deaths from pollution

Data from King's College published in 2018 by the government's Committee on the Medical Effects of Air Pollutants (COMEAP) estimated that between 28,000 and 36,000 people die as a result of air pollution every year in the UK. This is a significant increase on their 2015 figure of about 29,000.

The case of Ella Kissi-Debrah who died at the age of nine from severe asthma, highlights the consequences of not tackling air pollution. Ella lived near the South Circular Road in Lewisham, London, a hot spot for high air pollution. Ella had seizures for three years and 27 visits to hospital for asthma attacks until a fatal attack in 2013.

An inquest into her death in 2014 made no mention of air pollution as the cause of death, but her family always considered high air pollution episodes to have played a major role. In a report for the family presented to the attorney general in 2018, Professor Stephen Holgate, an expert on air pollution, suggested Ella might have survived if the air pollution around her home had not been so high.

In the UK, the government has consistently failed to take significant action on air pollution

As a result, the family's (the Ella Roberta Family Foundation) campaign for a second inquest was successful; in May 2019, the high court granted a new inquest into Ella's death. To date, no individual death has been linked directly to air pollution but if Ella's death is linked it would increase the pressure on the government to tackle the problem.

Despite the large body of evidence for its detrimental effects on health and life-span, the UK government and those across Europe have made little headway in tackling air pollution.

Failure of governments

In the UK, the government has consistently failed to take significant action on air pollution.

The activist organisation, ClientEarth, has won three cases in the high court against the UK government over its failure to deal with illegal levels of nitrogen dioxide pollution and in May 2018 after the most recent court loss, the UK government was referred to Europe's highest court.

Proposals for tackling air pollution were laid out in the Queen's speech, but measures are considered by campaigners to be too vague and weak.

Polly Billington, the director of UK100, told the Guardian that they "would like to see World Health Organization air pollution standards included in the bill, as they are widely seen as gold standard, with a legally binding timetable to meet them, as that creates certainty and enables long-term planning."

Earlier this month, the European Environment Agency published its Air Quality in Europe 2019 report, which brings together 2017 data from monitoring stations across Europe. The conclusion is that little progress has been made on tackling air quality in Europe.

Following more than 10 years of gradual declines, the levels of the dangerous fine particulate matter known as PM2.5, which can lodge deep in the lungs and pass into the bloodstream, appear to have reached a plateau across Europe.

In the UK, the monitoring station at Marylebone Road continued to record the highest level of nitrogen dioxide pollution in western Europe, despite falls in the overall concentrations of the gas.

How I went private without realising

When Madeleine Dickens went to her doctor in Brighton about an increasingly troublesome bunion, she was surprised and pleased to get a quick appointment with a consultant, but what she hadn't reckoned on was finding her NHS care being delivered in the private sector.

Persistent foot pain in her right foot had first driven Madeleine to her GP, who was happy to refer her to a specialist. They didn't discuss who this would be, so on the day of her outpatient trip she was not expecting to walk through the doors of a plush private health clinic in Burgess Hill.

"I was surprised on both counts [a consultation and in a private clinic], but in particular to not be going to the podiatry clinic at the Brighton General."

Madeleine is a member of a local NHS campaign group, so is more aware than most about the use of private companies in the NHS and because of her objections would certainly have opted to stay within the NHS if she had been given a choice.

After a short examination of her foot, the consultant proposed an operation, another surprise as Madeleine thought that under NHS guidelines a patient has to be almost immobilised to qualify for an operation and she certainly was not.

Further puzzlement followed when the confirmation letter arrived: "Much to my astonishment the only hospital proposed was the Gatwick Spire which I knew was a private hospital."

Madeleine immediately phoned the contact on the letter to say she didn't want to travel to Gatwick and that she wanted to be treated by the NHS. The contact said all they could do was to transfer her back into the NHS.

This seemed odd as at no time previously had she opted 'out' of the NHS, so why was she having to transfer 'back into' the NHS?

Back of the queue

The transfer 'back into' the NHS turned out not to be as easy as suggested, as when she phoned the NHS trauma and orthopaedic department a few weeks later they had no record of her, nor had they any record of the consultant Madeleine saw in the private clinic.

So as a result of not wanting to be treated in the private sector, she had effectively been shifted right to the back of the queue.

Madeleine's experience throws up numerous questions - at what point did Madeleine 'leave' the NHS? Why was she never given a choice of where her operation would take place? Why had she been offered an operation that appeared to go against guidelines? Why had nobody heard of the consultant?

Madeleine has now heard from others with a similar experience. She has also taken her case up with the local CCG and has now been put back into the system and not at the end of the queue. The CCG has also admitted that things had gone wrong in her particular case.

In Brighton and Hove, foot conditions are dealt with through the Sussex MSK Partnership, which is made up of Here (also known as Care Unbound, an employee-owned limited company), Horder Healthcare (a charity), Sussex Community NHS Foundation Trust (SCFT) and Sussex Partnership NHS Foundation Trust (SPFT).

The partnership operates as a not-for-profit organisation under contract to Sussex CCGs, including Brighton and Hove CCG. The contract covers taking patients from first referral from a GP or self-referral through the treatment process.

The transfer 'back into' the NHS turned out not to be as easy as suggested, as when she phoned the NHS trauma and orthopaedic department a few weeks later they had no record of her

Community clinic

According to the partnership's website, referrals are assessed by clinicians, with the most likely next step an appointment at a local community clinic with one of several different types of clinicians, such as a consultant, nurse specialist, physiotherapist or podiatrist.

If an operation is considered to be the best option, then the operation could be carried out by NHS hospitals in SCFT or SPFT or private hospitals, including those owned by Spire and BMI.

The use of the private sector for operations within the MSK pathway has grown steadily since 2014, coincidentally the year the Sussex MSK Partnership was set up.

As a result of a freedom of information request by a group of campaigners in Brighton & Hove it is known that from 2013/14 to 2017/18 the proportion of NHS-funded hip operations conducted in private hospitals increased from 24.5% to 54.5% per year and for knee operations the figure was 26.2% (2013/14) to 57.8% (2017/18) per year

In addition, the FOI found that the private hospitals were paid per operation and used their own selection criteria to choose patients. Operations on feet are also dealt with under the same contracts.

These figures show that over just a few years use of the private sector has sky-rocketed and it has become normalised in the NHS.

In Madeleine's case (and perhaps many others) patients are no longer being given a choice of NHS or private, but just shunted through the pathway.

Many people wouldn't have noticed that they were going to a private clinic for an appointment, and even if they did are unlikely to complain in the same way as Madeleine.

We have to hope that if they do, they don't also wind up at the back of the queue.

Concerns over quality of CQC inspections

The Lowdown is publishing a slightly abridged letter sent to CQC chair Ian Trenholm by the Campaign to Save Mental Health Services, which is focused on the Norfolk and Suffolk NHS Foundation Trust, which covers Matt Hancock's West Suffolk constituency. We at *The Lowdown* agree that the concerns they raise about the conduct of the CQC need to be shared – and answers need to be demanded.

For more than five years, the mental health services provided by Norfolk and Suffolk NHS Foundation Trust (NSFT) have been substandard and unsafe. As you know, NSFT has been rated 'Inadequate' by Care Quality Commission (CQC) inspectors three times and placed into Special Measures twice, where the trust remains.
We believe that people have died as a result of NSFT's failings and that NSFT is mental health's equivalent of Mid Staffs.

Until recently, CQC was one of the few parts of the NHS 'system' which genuinely wanted to listen to, indeed sought out, the voices of patients, carers and staff: the very people who use, rely upon and provide NHS services. The CQC met with us and others during the inspection process and took our experiences seriously, which NSFT, NHS England and the CCGs did not. For this, which we believe resulted in balanced inspection reports, we are extremely grateful.

However, since the last inspection and the appointment of a new Chief Executive at NSFT who was previously an employee of CQC, which has been followed by the appointment of one of the new NSFT Chief Executive's closest friends and former colleagues as CQC Deputy Chief Inspector of Hospitals and Lead for Mental Health, we and others have witnessed a worrying change of approach from CQC.

Previously, CQC maintained a professional distance and remained largely silent, quite properly as a regulator, between inspections: now the CQC Team Leader publicly praises the NSFT management, even when the trust's performance has deteriorated rapidly, as empirical evidence and patient and carer experience clearly confirms. …

More worrying has been CQC's changing attitude to engagement with those with experience of using or providing NSFT's front line services, which Sir Robert Francis said was key to preventing future scandals such as Mid Staffs. …

Prior to every previous inspection, we and other stakeholder groups were invited to meet CQC in the inspection period, usually during the inspection itself.

During the last inspection period, for instance, about thirty of us met CQC staff at the Maid's Head Hotel in Norwich, with similar meetings held with others. These meetings were arranged by the CQC Inspection Manager, who, we believe, is sadly no longer involved in the inspection process at NSFT.

We expected similar opportunities to be heard before the inspection currently underway and the CQC Team Leader indicated on 16 September 2019 that there would be such opportunities. She explained that these meetings had not been arranged in advance as:

'There will be opportunity to speak. We are doing the inspections on an unannounced basis so we have not announced when for obvious reasons'.

So, imagine our surprise when the timing of these so-called 'unannounced inspections' became widely informally known to NSFT staff several weeks ago and when the dates of these so-called 'unannounced inspections' were announced to NSFT staff by the Chief Executive of NSFT and former adviser to CQC, in the week before the inspections in Suffolk and a further week before inspections began in Norfolk and, indeed, before we and other stakeholders were told. …

What about our promised 'opportunity to speak' that could not be arranged because of the 'unannounced inspections'?

Since the 'unannounced inspections' were announced, we have heard nothing and neither have any of the other stakeholders who made submissions to whom we have spoken.

…

We submitted a thirty page report to CQC in July 2019 but have received not even an acknowledgement, never mind any follow-up.

We have spoken to other stakeholders who made submissions and they have not received acknowledgements or follow-ups either.

Since the promise of 'opportunity to speak', CQC appears to have changed its mind. …

We and other stakeholders to whom we have spoken have been invited to not a single 'focus group'. We have heard about a very limited number of internal NSFT focus groups at which CQC has referred to NSFT directors on extremely familiar terms and those raising genuine and important issues have been allowed to be shouted

Trusted sources from within the 'system' tell us that the NHS's regulators (NHS England, NHS Improvement and CQC) do not want to hear, indeed refuse to listen to, 'bad news' about NSFT

down by NSFT 'supporters' but that is all. The claim that 'we always want to hear all views' appears at best disingenuous.

We also note that that at the end of every previous inspection, there has been a feedback meeting for stakeholders and the local NHS 'system'.

Unlike previous years, those who would have expected to attend such an event have heard nothing from CQC.

Trusted sources from within the 'system' tell us that the NHS's regulators (NHS England, NHS Improvement and CQC) do not want to hear, indeed refuse to listen to, 'bad news' about NSFT.

We find these reports deeply disturbing, again with echoes of Mid Staffs. We wish to put on record our belief that NSFT being released from Special Measures before the evidence says so, is dangerous and has happened before at NSFT, with disastrous consequences.

We believe that such a decision would be at odds with the submissions received by CQC about NSFT. We challenge CQC to publish the various submissions it has received for the public to judge.

If CQC is unwilling to publish voluntarily, please consider this a request under the Freedom of Information Act for disclosure of stakeholder (not individual) submissions received regarding NSFT.

With the greatest of regret, it appears that the NHS 'system', including CQC, has decided that the best way to solve the serious problems at NSFT is to ignore the evidence and experiences of patients, carers and staff, to pretend that there are no serious problems and to release NSFT from Special Measures, which now appears predetermined, even before the inspection is completed. Indeed, we have heard this is the case from several independent sources. This is a shameful and dangerous situation.

From having almost complete confidence in CQC's impartiality and integrity, we now have virtually none.

We look forward to a full and prompt written response to our concerns. In the interests of transparency, we will be publishing this email.

Yours sincerely, Committee of the Campaign to Save Mental Health Services in Norfolk and Suffolk

Soon after weak-kneed councillors on North Somerset Council's health overview and scrutiny panel (HOSP) bottled out of referring the overnight closure of WESTON Hospital's A&E to the Secretary of State, arguing it would not achieve anything, campaigners in CHELTENHAM have been celebrating after securing a commitment by Matt Hancock in the House of Commons that their local A&E will not close.

CCG mergers get the nod

TWENTY Clinical Commissioning Groups covering over 5 million people are to be merged into just three as a result of the latest rubber-stamping of merger plans by NHS England.

South West London, South East London and Kent will each have just a single commissioning body from next April, with little likelihood that local concerns within these large areas will make any impact on plans being pushed through from above.

It's also rumoured as we go to press that the merger plans in North Central London have been nodded through, leaving only North West and North East London delaying their plans till 2021.

While many CCGs themselves, created as they were by the 2012 Health and Social Care Act to implement the process of carving up and contracting out an increasing number of clinical services, have been far from perfect, the loss of any local statutory body, and the concentration of power at a more remote level is still a significant loss of local accountability.

In Kent there are a number of hurdles to be surmounted before the merger, including delivery of the financial recovery plan this year, clear plans for how the financial position of Kent and Medway will continue to improve – and a decision in December on whether to determine whether the four east Kent CCGs can be released from legal financial directions.

Nonetheless the HSJ quotes a statement from Kent CCG managing directors making extraordinary claims for the benefits of merging organisaions which few patients or members of the public will have heard of:

"We strongly believe that having a single CCG will improve the quality of life and quality of care for our patients, and will help people to live their best life.

"It will save time, money and effort, freeing up GP time to see patients."

No evidence has been offered to show how life will be improved, or indeed significant GP time "freed up" by the merger.

Nor is there any explanation of why it was necessary to carry through this long-term change without bothering to consult the public covered by the merging CCGs, despite NHS regulations requiring them to do so.

Interestingly, just after Matt Hancock rubber-stamped plans for the downgrade of Telford's Princess Royal Hospital and the centralisation of Shropshire's emergency services in Shrewsbury, NHS England rejected proposals to merge Shropshire CCG and Telford and Wrekin CCG.

Local GPs in the north west and in Staffordshire have also stood up for themselves – and rejected CCG merger plans.

Why even the Americans don't want the US health care system

Continued fears that the NHS might be opened up to profit-grasping US health corporations in a post-Brexit trade deal have only been reinforced by repeated unconvincing denials from PM Johnson and trade secretary Liz Truss. So it's a good time to check out on how the world's most costly and inefficient health care system is working in the US. JOHN LISTER picks up on three recent published research papers.

Whose 'Medical Loss'?

One of the most telling jargon terms that gives a real insight into the insurance industry-led system created by Obama's Affordable Care Act (ACA) is "Medical Loss Ratio". Its topsy-turvy logic from the point of view of the patient or insurance policy holder is summed up neatly by the campaigning doctors of Physicians for a National Health Program (PNHP):

"Paying for health care is a loss for insurers. They get to keep for their administrative costs and profits whatever they do not spend on health care."

Insurance companies have always resented paying out: and it seemed to Obama' team drafting up the ACA that it could score political points by appearing to limit the scope of insurers to scoop profits from premium payments. As the PNHP puts it:

"In crafting the Affordable Care Act our legislators surmised that they could limit the administrative waste and excess profits by requiring that at least 80 percent of premiums be used for health care for individual plans and 85 percent for small group plans – the medical loss ratio."

No cap on profit levels

But as another paper points out the cap applies to insurer profit ***margins***, but not ***levels:*** in other words the way around the limitation is simply to expand the total amount of spending (and premium income collected), with the guarantee that the insurers can make 15-20% margin on any larger sum.

"If you were an insurer, think of the opportunity this offers," argues PNHP. Instead of trying to rein in costs, the new objective is to increase them to raise the global sum – and all the while getting subscribers to fork out the increased cost:

"How do you pay out more in health benefits? Simple. Negotiate higher prices with physicians and hospitals.

What the (research) papers say

Maximize benefits covered. Authorize more care …. Avoid adjusting claims and avoid claim denials. Do not investigate over-utilization or frank health care fraud."

Once the global cost has been inflated **"Then have your actuaries calculate the premiums to include 15 to 20 percent over the inflated health care spending. Make that a little bit over 15 to 20 percent which will then have to be refunded but will ensure that the full padded margin is received."**

No impact on spending

This was swiftly demonstrated as the ACA took effect In 2015 researchers noted that "the ACA had no impact on insurance industry overhead spending".

Two years later another team pointed out the nonsense of the ACA approach: an insurer making an additional 1% of surplus above the permitted level has to bear the full administrative cost of keeping expenditures below 80%, but reaps none of the rewards. As a result, **"minimum MLR requirements encourage higher costs, not lower."**

More recent figures show the extent to which this cynical policy is being implemented by the big insurers, who have over-inflated their costs to the extent of owing £1.37 billion to nearly 9 million policy holders from 2018-19: more than half of this is in the market for individual insurance, where 3.7 million Americans are owed refunds of £769m. These are the highest rebates since the ACA was put in place.

A large share of this ($217m) is down to Centene, one of the US insurers to show some interest in the NHS, and which has focused on lower income subscribers. At the top end, Sentara/Optima, which had the highest individual premiums in the US, owes each subscriber more than $1,200.

But don't cry for the insurers: after they suffered a brief period of losses in 2016 the larger rebates are the result of the most profitable year for individual insurers since the ACA was introduced in 2010.

The big insurers have over-inflated their costs to the extent of owing £1.37 billion to nearly 9 million policy holders from 2018-19

Mean-spirited nonprofits

For many who remain uninsured or under-insured while the insurers laugh all the way to the bank, the answer can often be seeking treatment in one of the USA's 2,508 "non-profit" hospitals, including 56% of community hospitals.

These are exempted from paying most taxes and allowed to float tax-free bonds – in exchange for giving free or discounted care to patients who can't afford to pay.

The IRS leaves it up to each hospital to decide the qualifying criteria; between them non-profit hospitals provide roughly $14 billion of charity care a year – about 2% of their operating costs.

Now Kaiser Health News has highlighted widespread abuse of this status by "non-profit" hospitals that dodge their commitments.

One of them, St Joseph Medical Centre in Tacoma, Washington recently settled a lawsuit from the state attorney general alleging they erected barriers to charity care, and agreed to pay up more than $27m in refunds and debt forgiveness.

Documents disclosed in the lawsuit included advice to heath workers on how best to pressurise patients to pay up, while patients were not offered application forms for assistance.

KHN reports nearly half (45%) of all nonprofit organisations (running 1,651 hospitals) are "routinely sending medical bills to patients whose incomes are low enough to qualify for charity care, with an estimated total of $2.7 billion in bills to patients who would have qualified for assistance if they had filled out application forms.

Over half the bad debts being written off by nonprofit hospitals in St Louis, Pennsylvania, Virginia and Memphis are owed by patients who should have received free or subsidised care.

Bad debts are absorbed into hospital running costs and eventually increase the rates charged to private insurers.

The only losers in the process are the patients, forking out insurance premiums or fleeced for charges they should not have to pay.

Annual wastage of resources is estimated to be between $760bn and $935bn, equivalent to around a quarter of the $3.7 trillion spent on health

Measuring US wasted spending

The excess costs passed on to insurers falls into the general category of "wasted" spending, which has been widely seen as costing as much as a third of the already inflated level of US health spending.

Now a new study has attempted to update these 2012 estimates and to assess what compensating steps are being taken to contain or eliminate waste.

It focuses on the 6 waste domains previously identified by the Institute of Medicine and the 2012 paper: failure of care delivery, failure of care coordination, overtreatment or low-value care, pricing failure, fraud and abuse, and administrative complexity.

Up to $935bn of waste

It now estimates annual wastage of resources on services other than paediatric care (for which there are no data available) to be between **$760bn** and **$935bn**, equivalent to around 25% of the $3.7 trillion spent on health: this might appear to be a step forward from the previous higher estimates, but they are still only estimates, and the sums of money involved are eye-watering:

Annual savings (with no schemes identified to address the problem of administrative complexity) are estimated to yield potential totals between $191bn and $282bn annually – equivalent to around 25% of the actual wasted money.

It's not clear how much of the "potential" savings are realistically likely to be achieved, or over what time frame: the system is so fragmented with so many perverse incentives it is hard to implement any coherent policy and – as we have seen above – there is little incentive for insurers to do so.

But even if they were achieved, it would still leave the US medical industrial complex squandering well over half a trillion dollars each year, and up to £653bn, in wasted spending.

Administrative complexity alone swallows up the equivalent of £205 billion – more than the entire NHS and social care budget each year, year – but delivering no benefit to anyone but corporate fat cats..

US annual bill for waste

Failure of care delivery,	$102.4 bn to $165.7 bn;
Failure of care coordination,	$27.2 bn to $78.2 bn;
Overtreatment/ low-value care,	$75.7 bn to $101.2 b;
Pricing failure,	$230.7 bn to $240.5 bn;
Fraud and abuse,	$58.5 bn to $83.9 bn;
Administrative complexity,	$265.6 billion

THE lowdown

In our first year we pledged to:

- 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.

To go into a second year we need **YOUR HELP**

The Lowdown launched in February 2019 with our first pilot issue and a searchable website. Our initial funding came from substantial donations from trade unions and a generous individual.

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – **something that was not previously available to NHS supporters.**

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.

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

The aim of the project has been to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

To get it under way, we have worked hard to get the name established, build a core readership, and raise money where we can.

We need to make the project self-sustaining, so we can pay new journalists to specialise, and undertake investigations and research that other organisations aren't able to take on.


THE lowdown

Health news, analysis and campaigns. NUMBER 11, October 12 2019

Informing, alerting and empowering NHS staff and campaigners

RCP warns of vacancies

Private GP service sets sights on further NHS expansion

Paul Evans

Babylon health plans to expand its virtual GP service to Manchester after its reported success in attracting NHS patients to use its GP at Hand business.

The private company, which offers fast GP appointments by video has attracted over 60,000 NHS patients in Birmingham and London and if its plan is accepted will be up and running in Manchester by early 2020.

The CCG backing the expansion to three major cities, under current regulations patients who sign-up for GP at Hand are all registered with Babylon Health's GP practice in Hammersmith & Fulham in West London; so it's this CCG that will be required to give approval for the expansion to Manchester.

Problems for CCG

Babylon's expansion in this way has led to major financial problems for Hammersmith and Fulham CCG as it is responsible for thousands of new patients registered on GP at Hand whether they live in their area or not.

The CCG eventually gave approval for the expansion to Birmingham, with the proviso that no more than 2,600 patients be registered in the area in the first three months.

However, changes announced in late September by NHS England and NHS

The app will see you now ...

New contracts for 'digital-first' GP providers will probably require them to set up a physical clinic in the area

Improvement will change this and have a significant effect on the way Babylon Health operates from April 2020 onwards when they come into force.

The new contracts will remove patient registration and mean that once 1,000 patients are registered in a CCG area by a provider outside this area, then the provider will be issued with a new APMS contract covering that area.

Financial burden

This means the patient list is divided up and no single CCG bears the financial burden of thousands of extra patients registering.

GP at Hand has approximately 60,000 patients living outside Hammersmith and Fulham, and these patients will now have to be divided into 17 different lists in areas where GP at Hand has more than 1,000 patients.

Other changes mean that in the areas where the new contracts are issued to the digital-first GP providers they will probably be required to set up a physical clinic in the area.

There is also a proposal that new digital primary care providers should be required to set up in areas lacking doctors and primary care access is poor.

Figures obtained by GPonline suggest that more than one in four NHS patients who registered with Babylon GP at Hand quit the video consultation service within just over a year.

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https://lowdownnhs.info/ contactus@lowdownnhs.info

We have had some success, and thank those individuals and organisations who have donated.

But seven months on, we need to step up our efforts to raise enough money to take us unto and through a second year, enough for us to be able to reach out and offer work to freelance journalists and, designers.

This autumn we will be making a fresh appeal to trade union branches, regions and national bodies – but also to individual readers.

We are providing this information free to all -- but it is far from free to produce.

If you want up to date information, backed up by hard evidence, that helps campaign in defence of the NHS and strengthens the hand of union negotiators, please help us fund it.

We urge those who can do to send us a one-off donation or take out a standing order.

More details of this and suggested contributions are in the box below.

Our commitment is to do all we can to ensure this new resource remains freely available to campaigners and activists.

Without your support this will not be possible.

Help us keep The Lowdown running in 2020

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 have therefore always planned to fund the publication through donations from supporting organisations and individuals.

We urge union branches to send us a donation … but also please propose to your regional and national committees that they invite one of our editors to speak about the project and appeal for wider support.

We know from our surveys that many readers are willing to make a contribution, but have not yet done so. We are now asking those who can to give as much as you can afford. We would suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can give us more, please do.

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

On the website we will gratefully acknowledge all of the founding donations that enable us to keep this project going into a second year.

- 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*