THE lowdown

Health news, analysis and campaigns.
NUMBER 17, January 31 2020

Informing, alerting and empowering NHS staff and campaigners

Imperial trust to bring 1,000 support staff back in house

1,000 low paid porters, cleaners and catering staff working in hospitals managed by Imperial College Healthcare NHS Trust are to be brought back in-house when the current five-year Sodexo contract ends at the end of March.

The Trust has decided not to put the contract out to tender again, but instead bring the staff into the Trust, with full Agenda for Change pay and conditions, initially for a year while a review takes place. The official statement says:

"we will undertake an evaluation after one year in order to decide whether to continue to employ hotel services staff directly - and bring all staff up to full NHS (Agenda for Change) terms and conditions – or re-tender the contract with a significantly amended specification."

UNISON, which brokered the deal with the Trust points out the significant pay increases from April 1:

"Employees' pay will increase from £10.55 to £11.28 an hour and they'll get sick pay from the first day they're ill. Workers will also be able to join the NHS pension scheme, which was previously unavailable to them as Sodexo staff."

The deal follows on nine days of strike action at St Mary's Hospital by members of United Voices of the World, and covers all support staff across the Trust's five hospitals, Charing Cross, Hammersmith, St Mary's, Queen Charlotte's and Chelsea, Western Eye.

Long A&E waits leave NHS vulnerable to coronavirus

The World Health Organization declared the outbreak a global emergency on January 30 after the number of confirmed cases spiked. More than 9,500 people had then been diagnosed with 2019-nCoV worldwide and at least 170 people had died in China as a result of the virus: that figure has since risen to 259.

Two cases have so far been confirmed in the UK, although a planeload of UK citizens has been flown back from Wuhan and put into isolation in a residential block in Arrowe Park Hospital.

Medical opinion differs on the threat posed by the virus which appears to be more contagious but less lethal than the SARS virus in 2003. However information is only gradually emerging and the threat could turn out to be much worse.

While people exhibiting the flu-like symptoms of the virus, which is related to the common cold, are advised to stay isolated and phone NHS 111 for advice rather than come to hospital, there is the danger that as papers like the *Daily Mail* whip up concerns among their readers some may decide to seek help from hospital A&E departments.

Long delays and crowding in many A&Es could prove a means to pass on the virus to significant numbers of patients, some of whom will already be in a vulnerable state.

The Wall Street Journal, warning of a similar potential threat in US emergency rooms, points back to the lessons from the SARS outbreak in Canada:

"A Toronto man, whose mother had come from Hong Kong two weeks earlier, went to the hospital with feverish symptoms. For 16 hours he was kept in a packed emergency department.

"His virus infected the man in the adjacent bed, who had come to the ER with heart problems, and another man three beds away with shortness of breath.

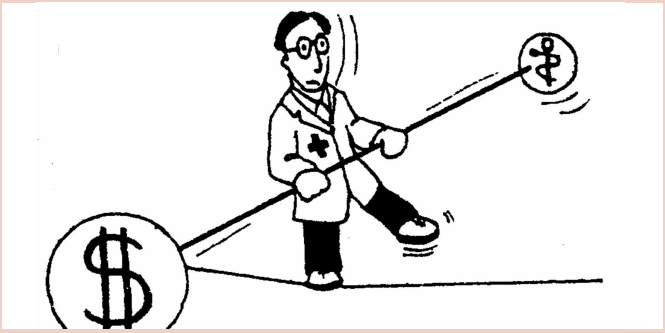
"Those two other men went home within hours but were later rushed back to the hospital, where they spread the virus to paramedics, ER staff, other ER visitors … and, later, staff and patients in the critical-care units."

We clearly don't want that type of thing happening here in Britain.

So trying to avoid panic reactions and extra efforts to ensure staff keep a close watch on all A&E patients as they wait could be vital.

IN THIS ISSUE

More stories and more detail on our searchable website



- NHS bosses discuss plans to deal with £10 billion trust debts

- Primary Care Networks – NHS England retreats under fire from angry GPs

- Children's mental health – a decade before it improves

In our next issue:

- North West London faces further cutbacks
- Poorest areas from former "red wall" constituencies could face social care cuts

Check out *The Lowdown* online

- An update on Integrated Care Systems: behind the rhetoric, how far have they really got?

- **The history of privatisation in the NHS** - part 1 of a new series

Babylon to link up with midlands hospital trust

The private digital GP provider, Babylon Health, has announced a 10-year partnership with Royal Wolverhampton Trust that aims to use technology to transform the way patients access healthcare.

The partnership claims to be the "world's first integrated digital healthcare system," and aims to create "joined up care" that allows patients to access NHS primary, secondary and community healthcare services through a single app.

The CEO of the Wolverhampton Trust, David Loughton has ambitious plans for the role of digital technology telling the Times, "I think 50 per cent of consultations could be done remotely."

Remote

The plans include remote access to GPs and hospital specialists, patient monitoring for those with chronic conditions and rehabilitation following hospital stays.

The Daily Mail reported that the "Royal Wolverhampton plans to sell the technology to the rest of the NHS if the partnership is successful."

Artificial intelligence will also be utilised to triage and provide medical information to patients, based on their symptoms.

The new partnership will provide a service for around 300,000 people across Wolverhampton and surrounding areas although David Loughton told the HSJ he does expect some flack from local GPs.

GPs don't like it

"They don't like Babylon. They see Babylon as creaming off the not very ill and [being] left with the not very fit, but you cannot possibly just stay with that view."

But he is determined to plough ahead quoting the scale of workforce challenges as a major reason for the new approach.

Babylon claims to be able to utilise a national network of clinicians to help free up local clinicians to spend more time with complex patients.

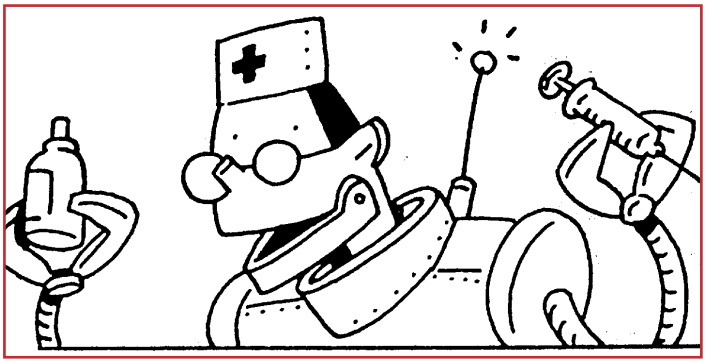
Babylon's existing services

Babylon Health has a contract with NHS England to register patients to the GP at Hand app.

The Royal College of GPs and BMA have both criticised the service for 'cherry picking' younger, healthier patients. This leaves other GP services to deal with patients requiring more complex care.

Babylon's diagnosis software has also come in for criticism. An anonymous NHS doctor who tweets under the name @DrMurphy11 has tested the Babylon app repeatedly, highlighting failures in its ability to detect potentially fatal health conditions.

More on Babylon Health from our Lowdown Q&A



Help us keep The Lowdown running in 2020

We really want to keep running 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.

Having managed to raise enough money for our first year we now urgently need more to keep going.

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 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 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.

● **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*

In our first year, as promised, we:

● established a regular one-stop summary of key health and social care news and policy
● produced articles highlighting the strengths of the NHS as a model and its achievements
● maintained a consistent, evidence-based critique of all forms of privatisation
● published analysis of health policies and strategies, including the NHS Long Term Plan
● written explainer articles to promote wider understanding
● created a website that gives free access to the main content for all those wanting the facts
● pursued special investigations into key issues of concern, including those flagged up by supporters
● connected 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.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Long A&E waits leave NHS vulnerable to coronavirus

IN THIS ISSUE

WHO WE ARE – and why we need YOUR help to sustain The Lowdown - p3

OPINION: NHS commentator ROY LILLEY kicks off our new guest column Back

NEW HOSPITALS – but NHS still faces still same old bed shortages 4-5

4-HOUR TARGET saves lives – important new 10-11

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.

New hospitals won't end bed shortages

John Lister

Management at Whiston Hospital, which only opened in 2010, have applied for permission to install a 2-floored Portakabin in the car park to provide 60 extra beds.

Whiston's A&E is the busiest on Merseyside, and the St Helens & Knowsley Trust is concerned that sky-high bed occupancy levels can lead to "inappropriate" levels of care on wards and result in a lower rating from the Care Quality Commission.

Whiston was part of a £338 million redevelopment, which also included the opening of the new St Helens Hospital. Just ten years later, having already paid a staggering £462m in unitary charge payments, and with over £2.2bn more to pay on its 42-year Private Finance Initiative contract with runs to 2048, it is too small and resorting to desperate measures to expand capacity.

According to the Liverpool Echo the planning application states that the Portakabins would be in place for "a minimum of five years" in order to "bridge the gap until the more permanent solutions, both on-site and in the community, kick in".

With no prospect of any extra allocation of NHS capital for expansion until at least 2024 this sounds like wishful thinking.

But even the six new hospitals that have been given the go-ahead since Boris Johnson took over as Prime Minister last July are already faced with the prospect of bed shortages and inadequate capacity – before a brick is laid.

One example is the new specialist emergency care hospital which is to replace most of the front line services provided from 1,048 beds by **Epsom and St Helier hospitals** in South West London. The CCG will put the decision on where it should be located out to consultation, but have already decided that their favoured option is Sutton.

Downgraded

The opening of the new hospital, which will be very much dominated by the needs of the Royal Marsden Hospital next door, will mean the both of the existing hospitals providing A&E, Epsom General and St Helier in Carshalton would be downgraded to urgent care only.

Six core (major) services, the emergency department, acute medicine, emergency surgery, critical care and children's beds for the most unwell patients, those who need more specialist care, and women giving birth in hospital would be provided only on the one new hospital site, with just 496 beds.

So even if some elective work is retained at Epsom and St Helier and bed numbers remain unchanged, the big question is how would the new hospital cope with this reduction in front line beds? And is £500m anywhere near enough to provide the mix of services proposed in the consultation?

Leicester is another one on the list of six new hospitals to be built – and another where there are more doubts than certainty on whether the plan is viable or affordable for the money available.

January's meeting of the University Hospitals Leicester trust Board heard that urgent and emergency care continues to be "extremely challenging," with a 5.4% increase in emergency admissions in November 2019 compared to November 2018.

Leicestershire campaigners protesting at the obsessive secrecy of health chiefs who have still not published their massive preconsultation document

But the last detailed plan for health care across the county, the 2016 Sustainability and Transformation Plan, called for a hefty – and unachievable – reduction in bed numbers by 243, 12.5% of the total, by 2020-21.

The most recent winter sitrep reports show that even with 82 "escalation beds" open the trust is consistently running with well over 90% of beds occupied.

In December the trust only managed to see and treat 58.5% of the most serious Type 1 emergency patients, and the lack of beds kept over 2,300 patients waiting over 4 hours on trolleys after a decision to admit them.

Since then an extensive Preconsultation Business Case has reputedly been drawn up under a total blanket of secrecy: rumour has it the document could be as much as 1500 pages long.

But it has not been released for any pre-consultation with the public in Leicestershire, quite likely because health bosses fear the critical eye of local campaigners could swiftly demolish the assumptions and wishful thinking if it were revealed.

Protests demand end to secrecy

We now have the curious situation of a looming deadline of late March to launch the full consultation (which has to precede any business case to release the funds for the new hospital), but no clarity on the extent to which reality has forced a change in the planning assumptions of 2016, and no public discussion having taken place on the "pre-consultation". Campaigners have begun to protest outside local meetings demanding an end to the obsessive secrecy.

In **Leeds t**here is little pretence that the "new" hospital will add any significant number of beds, even though the latest statistics show the trust's beds 98% full on January 19, even with 147 extra beds (almost an extra 10%) open. Most of the new buildings will simply be replacing and

upgrading what's already there.

The section on Leeds in the West Yorkshire STP in 2016 made clear the aim was to provide fewer services: "We need to encourage greater resilience in communities so that more people are able to do more themselves. This will reduce the demands on public services and help us prioritise our resources to help those most at need."

In line with this, the press release on the funding for the new development at Leeds Teaching Hospitals Trust listed the "fantastic new facilities" that the money would be used for, with no mention of any extra beds:

- expanded critical care services to support the delivery of highly specialist treatments
- brand-new, state-of-the-art theatres as part of a dedicated theatre suite for day case procedures
- a high-tech radiology department that will serve other specialties in the hospital
- one central department for all adult Outpatient services. This will be supported by the latest technologies and key services, including pharmacy
- a therapies hub
- a new facility for endoscopy services.

KONP Co-chair Dr John Puntis, who lives in Leeds told the Lowdown:

"The Leeds Health Plan as everywhere else of course envisages a reduction in hospital activity as more care moves into the community (here this is called 'the left shift'). Bed cuts were justified in the past on the basis of 'a computer model' which demonstrated our inefficiency in relation to comparator hospitals and therefore indicated we could manage with less beds.

"I could never get out of the managers how this model had been developed and tested - they just accepted it at face value.

"I don't think there would be many (if any) clinicians who think there is further scope to reduce admissions or that there are currently enough beds."

No new hospital for Herts

West Hertfordshire Hospitals Trust's long-running plan for a rebuild on the existing **Watford General** Hospital site, finalised last July, is one of the few current plans that is proposing a larger building and another 70 beds. Chief executive Christine Allen pointed out that this would not be a new hospital:

"while we recognise that some communities would like a new hospital, we have chosen the option we believe is most likely to secure funding."

The West Herts allocation of £400m is higher than the £350m that had previously been assumed to be the most that could be secured, but well short of the £750m estimated cost of a new hospital in the Strategic Outline Case.

However the money must also cover investment to retain some form of hospital services in **St Albans** and in **Hemel Hempstead**, although neither of these will have any emergency services. The Trust has 660 beds in operation this winter, plus 28 escalation beds, and was 93% full on January 19.

West Herts is also the only trust to openly mention the question of affordability: "In the meantime, we do know that the funding will be made available on the basis, as expected, that this operates like a loan and there will certainly need to be repayments."

By contrast the second London project to get the go-ahead, **Whipps Cross Hospital,** part of the giant **Barts Health** trust, has made clear from the start that it will be a new, taller building on about one fifth of the site of the present hospital, releasing the remainder of the site for housing.

Leeds Teaching Hospitals Trust lists the "fantastic new facilities" that the money would be used for, with no mention of any extra beds

A glossy promotion pamphlet showing futuristic buildings makes no mention of bed numbers but it's highly unlikely the new building will have any more beds than Whipps now has to deal with its large catchment population in Waltham Forest and surrounding NE London boroughs and parts of Essex.

Harlow's Princess Alexandra Hospital (PAH) seems to be one of very few completely new hospitals on the list of new projects: the Trust Board decided after a public meeting last autumn that it did not want to attempt to rebuild on the existing site, but to build on a greenfield site by Junction 7A of the M1.

PAH chief executive Lance MCarthy warned the Board that the new hospital is unlikely to be open until 2025, and that the Trust itself does not have "the required skillset for a project of such size" – so will no doubt be in the market for management consultants as an additional resource to fill in the gaps.

There are still no details on the likely size of the new hospital, although earlier plans have included a 424 bed hospital with a total of 633 "care spaces". The current one with almost 400 beds is consistently over 90% occupied even with an extra 24 escalation beds open.

Not enough cash

These six newly authorised projects are not the only ones with management wondering if the money they have been allocated is enough to pay for the new buildings they need.

In **Shropshire** the projected cost of the 'Future Fit' plan, to downgrade services at **Telford Hospital** and "centralise" emergency and specialist services in **Shrewsbury** has increased by 60%, from the £312m that has been allocated to an eye-watering £498m. Campaigners reckon local health chiefs have probably known for years they'd got their sums wrong – but chose to keep it quiet.

So while ministers continue to boast of the limited extra funding they will be giving the NHS after a decade of real terms cuts, the question is how far short this extra funding will fall, and how trusts desperate to renew crumbling buildings and clapped out kit can draw up realistic plans to deliver adequate capacity for decades ahead – and find the cash they need to make it happen.

Luton hospital unions fight to get services in-house

Luton and Dunstable FT management have clearly learned nothing from the five years of erratic services they have had from private contractors Engie since they decided to put cleaning and catering services out to tender.

Services which had been consistently rated at 99% when delivered in-house have since 2015 required repeated trust intervention and "remedial" action.

Trust bosses have already made clear they don't want to extend the Engie contract, but with the contract due to expire later this year they have also ruled out the obvious option of bringing the services back in-house, claiming this would increase costs.

Instead they are proposing to invite bids for a ten year contract to deliver an increased range of services for a pathetically low £55m per year – while Engie managers have told the unions the realistic cost would be more like £80m.

UNISON and GMB have launched a determined campaign to force the trust to change course and bring services back in-house.

A lively meeting on January 30 kicked off the campaign, publishing a report *Quality Pays* by Lowdown co-editor John Lister, making the case for bringing the outsourced services back in house.

A board outside the hospital proclaims the trust's commitment to "clinical exellence, quality and safety."

Will the trust dump these values for short term savings?

Mansfield Commission members Dr Stephen Hirst (left), John Lister (centre) and Michael Mansfield QC (right), with council leader Steve Cowan (behind), and campaigners Jim Grealy and Merril Hammer at the ceremony on January 22.

Borough honours campaigners for rescuing Charing Cross

The London Borough of Hammersmith and Fulham has given its highest civic honour of Freedom of the Borough to three of the leading local campaigners who fought so hard and for so long to defeat plans for the closure of Charing Cross and Ealing Hospitals.

The same award has also been given to the three members of the independent commission led by Michael Mansfield which, in a series of hearings in five of the NW London boroughs affected, reviewed the Shaping a Healthier Future plan and exposed its lack of evidence and viability.

The Commission helped ensure the plan was eventually axed by Matt Hancock last year, lifting the threat to both hospitals.

German based company pulls ahead in south London pathology bid

The German company Synlab has been announced as the preferred strategic partner for a pathology contract worth £2.25 billion over 15 years. The contract covers a large chunk of south east and central London.

The incumbent provider Viapath, a company jointly owned by Serco, Guy's and St Thomas' Foundation Trust and King's College Hospital FT, has held the contract since 2009.

The other unsuccessful bidder was HSL, a partnership between the Australian company TDL, University College London Hospitals NHS FT, The Royal Free London FT and North Middlesex University Hospital.

The contract covers the provision of pathology services to South London and Maudsley FT, Oxleas FT, the Royal Brompton and Harefield FT, and to Guy's and King's FTs, the two trusts who jointly own Viapath. The boards at Guy's and King's FTs will now have to approve the appointment of Synlab.

If Viapath loses this contract, the company will have no significant NHS contract. Synlab, which, with was bought out by British-based private equity group Cinven in 2015, operates in the UK as the wholly owned subsidiary iPP (Integrated Pathology Partnerships).

iPP was set up in 2010 specifically to seek partnerships with the NHS, and is involved in Southwest Pathology Services and Pathology First.

The latter is a collaboration between Basildon and Thurrock University Hospitals FT and Southend University Hospital FT which provides pathology services across south Essex.

If Viapath loses this contract, the company will have no significant NHS contract.

In the same week as the London announcement The *Health Service Journal* reported that The West of England Pathology Network – which comprises acute NHS trusts in Bristol, North Somerset and Gloucestershire - has rejected proposals from NHS Improvement (NHSI) to centralise laboratories in the region.

When asked to rate seven proposals for redesign, the members of WEPN rated the NHSI proposal as lower than the "do nothing" option.

The WEPN will now explore three other pathology reconfiguration options. The highest scoring option was a "virtual hub", in which the network centralises some specialist testing, and possibly IT and/or training, but with all laboratories remaining in use.

NHS England has been encouraging the redesign of pathology services for over a decade, and although it did not explicitly advocate private company involvement this has led to a large amount of privatisation.

In September 2017, NHS Improvement reiterated calls for the development of pathology in line with the 'hub and spoke' model and its plans to create 29 pathology networks across England in a bid to save £200 million by 2021.

By November 2019, 16 of the regions had formally agreed new models, up three from September 2018, but 13 have yet to formally commit to new pathology models. It also appears that some trusts which had formally agreed on a model last year, no longer do so.

False economy of cutting public health and preventive services

Sylvia Davidson

Cuts to the public health budget of local authorities are putting the government's goal of a smoke-free England by 2030 at risk, according to the new report - Many Ways Forward - from Action for Smoking and Health (ASH) and Cancer Research UK.

This annual survey of local authorities found that due to cuts, a third (31%) no longer provide a specialist stop smoking service, and three quarters (74%) say that budget pressure means that their stop smoking services are threatened.

Cuts to public health budgets mean that spending on stop smoking services and tobacco control fell by 36% from 2014/15 to 2018/19, according to the report.

The survey also looked at what was provided around England for those trying to give up smoking. In a quarter of local authorities GPs did not prescribe any nicotine replacement therapy (NRT), despite guidance that to give smokers the best chance of quitting they should be offered a combination of NRT or the drug varenicline, in conjunction with behaviour support.

Of the local authorities that still had specialist stop smoking advisors, 21% had advisers that had had less than two days training, which ASH notes is not adequate training in line with nationally recognised standards to give effective support to smokers.

One in ten

One in ten local authorities only offer a stop smoking service via primary care and these services are the least likely to be targeting groups with a high prevalence of smoking, although ASH notes that this is key if the inequalities in smoking are to be addressed.

There are also 2% of local authorities that only offer stop smoking support by telephone.

ASH and Cancer Research UK say that cuts to the budget need to be reversed if prevention targets are to be achieved, but also advocate a "polluter pays" strategy: Deborah Arnott, Chief Executive of Action on Smoking and Health (ASH) said

"To fund the support smokers need to quit, the Government should impose a 'polluter pays' charge on the tobacco industry which could raise at least £265m annually.

"This could adequately fund stop smoking services, local authority enforcement against the illicit tobacco trade and underage sales, and adequately funded public health campaigns to reduce smoking."

False economy

Although focused on anti-smoking services, the survey is yet another example of how budget cuts are setting back plans to improve the health of the population. In the long term, skimping on such services does not add-up financially - according to Cancer Research UK, smoking is the biggest preventable cause of cancer and every year smoking related illness costs the NHS £2.5 billion.

Indeed overall, ASH calculates that smoking in England costs society £12.5 billion each year, costs include healthcare, social care costs, house fires, and loss in productivity. Yet the entire budget allocated to local councils for public health is only £3.1 billion and a small and reducing proportion of this is allocated to smoking cessation. Since 2014, the public health budget has fallen by £850 million.

"To fund the support smokers need to quit, the Government should impose a 'polluter pays' charge on the tobacco industry which could raise at least £265m annually."

Inequality

In late 2019, a report from the IPPR compared those public health cuts in the most and the least deprived ten local authorities, and showed that the absolute cuts in the poorest places were six times larger than in the least deprived.

In relative terms, the poorest ten places have lost approximately 35p in every £1 of their budget, compared to the least deprived areas where approximately 20p in every £1 of their budget has been cut.

When individual services are considered then it's smoking services, drug and alcohol services and sexual health services that have taken the brunt of the cuts, according to the IPPR, down 85.1%, 260.9% and 196.4% from 2014/15 to 2019/20 spending levels.

Charities have called upon the government to increase the funding allocated to public health by £1 billion to bring it back to the 2014 level, without this the government's aim to prevent ill health and increase the number of years spent in good health outlined in the long-term plan in 2019 will be impossible.

Although the government signalled that there will be a real term increase in money for public health in its provisional local government finance settlement for 2020/21, the Local Government Association noted in late December 2019 that the settlement includes no information about the national total, or individual council allocations, of the public health grant for 2020/21.

The LGA called on the government to provide councils with clarity on the funding available in 2020/21, saying the delay to the announcement is making it extremely difficult for councils to plan effectively.

Worse services in poorest areas

NHS policies speak of reducing inequalities in health, but there is growing concern that welfare and social care spending cuts are causing inequalities to widen.

Now a new report from the Nuffield Trust points out that the same contradiction applies to health care: "There is also evidence that the Inverse Care Law is persisting in primary care. … This may be affecting deprived areas to a greater extent, resulting in a double deficit, where people in these areas have greater needs but also poorer access."

CSUs hit by CUTS

Nicola Redwood

David Cameron and George Osborne as part of the general election campaign in 2010 repeatedly pledged that there would be no more of the tiresome, meddlesome, top-down reorganisations that had dominated in the NHS in the previous decade.

Later that year, a white paper came out, Liberating the NHS, and it became clear this would become the biggest top-down reorganisation in the NHS had ever seen. So much for that pledge

At the time, I was working in IT for Greenwich Teaching PCT and a Unite Workplace rep. Then came the provider split. I was involved as Staff Side Chair in endless meetings whilst decisions were made on our future path.

I ended up in an IT role in NHS South East London PCT cluster after the biggest and most complex HR transition change management I'd ever been involved in as a rep.

It was a difficult time and we lost quite a few people in the process through redundancy or resignation. I never wanted to go through anything like that again.

But on 1st April 2013 I found myself working for something called a Commissioning Support Unit (CSU) when the Health & Social Care Act came into law.

CSUs are a little-known part of the NHS. 19 CSUs were set up in 2013: there are now only five.

In 2013, CSUs employed over 9,000 staff: this has fallen to around 7,000. They are "arm's-length" bodies of NHS England. Our legal employer is NHS Business Services Authority.

CSUs offer little information to the outside world about how they operate, their purpose or their decision-making process. Their purpose is to provide advice and back office functions including recruitment, HR, Finance and IT to Clinical Commissioning Groups (CCGs).

Core business

IT contracts for CCGs and GPs are core buiness for CSUs. The more significant role of CSUs is the role they play as the door through which the private sector is brought in without public scrutiny: the 2013 NHS England document ***Mapping the Market*** listed 23 private companies that could be involved in the work, and noted:

> "Although CSUs and independent sector providers are still finding their place in the market, at present, there is an emerging trend of independent sector providers working through CSUs to provide commissioning support rather than working directly with CCGs."

CSUs don't produce annual reports or financial accounts like other statutory NHS organisations. Working for a CSU is completely different to working for any other part of the NHS, and there is almost no transparency.

As a union rep, my role certainly isn't made easy. I work in a small team providing IT support (servers) to CCGs and GP practices across South London. However with so many reorganisations, in-housings and TUPE transfers there are times when I'm doing my day job less than I'd like.

My part of the NHS has seen more top-down reorganisation than I ever want to see again in a lifetime.

Fast forward to today. The mental health of staff and a blame culture are key issues every year in our NHS Staff Survey results.

We're now seeing another big change in the NHS in England, part of the sustainability and transformation plans. CCGs are merging in STP footprints right across England in 2020 and 2021 to pave the way for them to become Integrated Care Organisations (ICOs).

The NW London STP has been discussing derecognising trade unions, and there is little partnership working with unions. Each reorganisation experience is getting more painful and many of the good people are going.

December 2019 saw yet another consultation on reorganisation, due to yet another round of 20% cost efficiency savings needing to be made by CCGs.

This has a knock-on effect on CSUs, which get most of their income from CCGs. My CSU has lost multiple contracts, mostly in IT, leading to a significant financial challenges.

239 staff out of a total headcount of 1,574 are potentially at risk of redundancy. This is in the context of a still too-high spend on interim and agency staff.

We won't know for a few months how many jobs will be lost in total across the CCGs and the CSU: it is likely to be between 100 and 200, but could be lower.

For the CSU, this is a complex reorganisation with many transfers in and out to be consulted on separately. My own team is being cut by half, with a proposal to move us out of London as well

Evidence shows that constant change causes instability and poor performance, and morale is extremely low.

This is accompanied by a rise in the number of employment relations cases and sickness absence putting even more pressure on us union reps.

Enough is enough. With an unprecedented number of disputes across the NHS in the last 12 months, and services being decimated by cuts, NHS workers need to stand together as a collective and fight back.

Inquiry will scrutinise NHS implementation of migrant health charging

Tony O'Sullivan

A new panel of inquiry has been set up by Lewisham & Greenwich NHS Trust (LGT) to investigate the implementation of 'overseas charging' policy at the trust and the trust's partnership with credit checking company Experian from 2013 to 2019.

The revelation late last year that the deaths of three mothers in the UK have been linked to the Government's migrant charges policy places a heavy weight of responsibility on the inquiry, knowing that the lives and health of patients are at stake.

This inquiry is important and probably the first of its kind. It is a welcome development and a direct result of campaigners from the Save Lewisham Hospital Campaign (branch of Keep Our NHS Public) challenging the trust on why it was responsible for referring a higher number of invoiced to debt collectors than any other trust in England.

Unable to pay

Last March *The Guardian* reported on NHS patients who had been unable to pay invoices often amounting to thousands or tens of thousands of pounds, and referred to debt collection agencies in England.

In LGT's case, it passes on unpaid invoices to the joint venture company, NHS Shared Business Services (SBS).

Between 2016 and 2018 1,085 unpaid LGT patient invoices worth £5.4m were passed on by SBS to debt firms CCI and LRC. This was the highest in England. And yet only £88,000 was recovered – a mere 2% - a sign many would say that the scheme was more a part of the hostile environment than a rational policy.

Campaigners had also questioned the trust on the link between its partnership with Experian and the high number of patients identified for invoicing.

Before they could get an answer, the *HSJ* disclosed in September that NHS Improvement had suggested to 51 NHS trusts that they might approach Experian, to copy the LGT scheme.

This proposal from the regulator to extend data-sharing on an industrial scale was unaccompanied by any legal advice on the lawfulness or ethics of the scheme.

Question over legality

Lewisham & Greenwich Trust was forced into the limelight when a report in a south London newspaper questioned whether LGT's large-scale data-sharing was ethical or lawful, and quoted MedConfidential's questions highlighting LGT's partnership with Experian,.

To be clear, Experian was not doing credit checks on patients. But it was using its database to process large batches of NHS patients' data in order to confirm who had an 'economic footprint'.

Experian was not doing credit checks on patients. But it was using its database to process large batches of NHS patients' data in order to confirm who had an 'economic footprint'.

They relied on that as 'evidence' that those with footprints were ordinarily resident in the UK, and assumed to be entitled to NHS care without charge. The trust excluded them from further challenge, and focusing on patients without such a footprint – even though this is in many cases linked to poverty, lack of bank account, credit cards etc.

The trust has responded positively following these revelations and has set up the panel of inquiry into 'Overseas Charging', headed by an independent chair and with campaigners on the panel. LGT has now told the HSJ they will no longer use Experian.

Director of Integrated Care and Development at LGT Jim Lusby argued the trust took the decision to carry out checks on everyone "in order to avoid discrimination," but has now said "In hindsight it was not the right choice. In all honesty I struggle to defend the logic of this",

In fact the government's own MESH database can now offer virtually the same functions as the Experian checks.

Scrap charges

Nationally, the call to scrap the migrant charges scheme is gaining in strength, backed by the Royal College of Midwives, the BMA and the Association of Medical Royal Colleges (AoMRC).

Public campaigning will continue outside of the Lewisham panel, which will be looking at how these policies might threaten access to prompt and safe clinical care if patients are fearful of approaching NHS services lest they receive unpayable bills and are referred to the Home Office.

Mothers have even been invoiced following stillbirth or miscarriage. Locally and positively, the trust has changed policy on this. But across the land patients have been scared away from services they need.

The outcome from the Lewisham inquiry could not only lead to safer and more compassionate practice but crucially also add weight to the call to repeal these oppressive laws.

4-hour A&E target saves lives – official

John Lister

Performance in England's A&E departments has fallen to new lows after a decade of under-funding and real terms cuts in spending alongside an increased population and a rising proportion of older people.

The target of treating or discharging 98%, and later 95% of A&E attenders within 4 hours has not been reached by England's NHS since 2015. So ministers such as Matt Hancock, despairing of ever regaining the consistently high performance levels achieved in the late 2000s, have looked to ditch the embarrassing target – effectively moving the goalposts – rather than tackle the underlying lack of resources.

The Royal College of Emergency Medicine is one of a number of professional bodies that have challenged Matt Hancock's apparent wish to ditch the 4-hour target that is enshrined in the NHS Constitution. Dr Katherine Henderson, the president of the RCEM said:

"So far we've seen nothing to indicate that a viable replacement for the four-hour target exists. Rather than focus on ways around the target, we need to get back to the business of delivering on it."

Susan Crossland president of the Society for Acute Medicine, which represents specialists in hospital care of the very sick, put it more bluntly: "Potentially scrapping the target because it is no longer being met shows the disregard this current government has for improving patient care."

Crucial

The Royal College of Physicians, stressed that the target had "played a crucial part in driving improvements in waiting times for patients," and the BMA has also spoken out against dropping or diluting the target.

The RCN's Emergency Care Association, representing 8,000 A&E nurses, told the HSJ that "it could cause significant detriment to patient safety within our emergency departments if the four-hour target was abolished."

The problem in A&E is not the large numbers of minor cases, so-called "Type 3" A&E attenders, who might otherwise have been treated by GPs or by nurses in an urgent treatment centre: almost all trusts consistently treat and discharge close to 100% of them within the 4 hour target.

Instead, perversely, it is those with the most serious health needs, the Type 1 patients, who face the greatest delays, mainly for lack of beds to admit them to hospital.

But Britain is not alone in struggling to deliver prompt emergency care: according to a new study recently published by the Institute of Fiscal Studies:

"there remains dissatisfaction in most health care systems with the level of crowding in EDs and the speed with which cases are resolved."

What was unique to England's NHS was the imposition of the 4-hour target: but while those embarrassed by performance figures like Hancock try to argue it is now out-dated and clinically inappropriate, the IFS report, researched jointly with Cornell University and the Massachusetts Institute for Technology (MIT) shows that it has brought significant and tangible benefits to patients:

"We study one type of regulatory intervention, the four-hour wait target policy enacted in England. We find that this target had an enormous effect on wait times …
"We find this target led to a significant rise in hospital admissions. …
"At the same time, we find striking evidence that the target is associated with lower patient mortality. There is a 0.4 percentage point reduction in patient mortality that emerges within the first 30 days, amounting to a large 14% reduction in mortality in that interval. …
"While modest, this effect is large relative to the extra spending…
"Finally, we … show that this effect arises through reduced wait times, not through increased inpatient admissions." (p29-30)

The researchers find that the target creates a characteristic – and apparently unique – "spike" in numbers of admissions as the 4-hour target grows closer, with more than 10% of patients being admitted in the final 10 minutes before the deadline is reached.

"This spike is unlikely to naturally occur, and is instead induced by the target. We cannot illustrate the absence of this spike prior to the wait times target, since we do not have systematic data available from that period. But it is worth noting … that such a spike is not present in data on ED wait times from a major U.S. hospital." (p11)

The researchers estimate that the target has been successful in reducing average waiting times by around 20 minutes.

"Given the large number of A&E patients affected by the target each year, these estimates imply that the target resulted in around 15,000 fewer deaths in 2012-13 alone."

Increased admissions

It's clear from the figures that one impact of this has been to increase the numbers of patients admitted, including some with relatively minor needs, and as a result increased spending and marginally increased average costs of A&E services (by an estimated 5% or so)

However the tangible health gain flowing from the reduced waiting times is a new finding from the research. One of the research team, George Stoye, reports in a summary of the paper that:

"The target also led to large reductions in the number of patient deaths. Patient mortality within a year of visiting A&E fell by 0.3 percentage

points among the patients affected by the target, reducing the probability of mortality among this group from 9% to 8.7% as a result of the policy.

"Given the large number of A&E patients affected by the target each year, these estimates imply that the target resulted in around 15,000 fewer deaths in 2012-13 alone."

The paper goes on to ask the question of whether it is lower waiting times or the fact that more patients are admitted to hospital that saves lives?

Importance of waiting times

Some complex statistical comparisons produce evidence that larger mortality reductions flow from the reduced waiting times: there is no relationship between numbers of admissions and deaths.

It also shows that the biggest reductions in mortality rates are among patients with potentially serious conditions that benefit from timely treatment, with the largest impacts found among sepsis, heart attack and stroke patients:

"By contrast, there is no impact on patients with a number of different cancers, serious conditions which are less time-sensitive…"

In addition to researchers shoot down any suggestion of simply "fast-tracking" patients with the most serious and time-sensitive conditions:

"There is often confusion over the exact diagnosis of patients upon arrival, and identifying which patients are covered by the target might not always be obvious (and could even lead to hospitals 'manipulating' recorded diagnoses to better hit the target). Indeed, the current policy appears to be so effective because it means that patients who should be treated quickly – but who are not diagnosed or treated as quickly as they would optimally be – are treated faster."

In other words simply fast-tracking treatment of patients with specific conditions but not others "risks losing the benefit that the current policy provides for hard-to-diagnose patients."

The unexpected intervention of the IFS, with its reputation for impartiality and reliance on solid figures, further strengthens the hand of the professionals before the real showdown with Hancock when the results of the ongoing "review" are revealed.

Safety warnings amid increase in "corridor nursing"

The chronic and continued shortage of front line acute beds in NHS hospitals, with times of highest demand not restricted any more to the winter months, there has been a growing trend of hospital management to nurse patients in corridors, despite warnings from the Royal College of Nursing.

"Patient safety is being compromised too often at present," according to Dave Smith, Chair of the RCN's Emergency Care Association.

He told Nursing Notes "Having to provide care to patients in corridors and on trolleys in overcrowded emergency departments is not what we came into nursing for. It's not just undignified for patients, it's also often unsafe.

Perhaps it's no surprise to find that the RCN's focus is on the numbers of nurses ("this problem isn't going to go away unless we can increase the number of nurses in the health service.") rather than the supply of sufficient beds in properly-appointed wards, as argued for by the Royal College of Emergency Medicine. It's hard to see an increase in staff on its own being sufficient to get patients off trolleys.

The continued increase in average bed occupancy levels, and the much worse performance on waiting times for the more serious Type 1 A&E patients, many of whom have to wait for beds long after the decisions to admit them point to this as the underlying problem, although obviously more beds without sufficient nursing and other staff to care for the patients is no solution either.

Nursing Notes also reports on the email sent by an advanced nurse practitioner in Grimsby Hospital begging senior trust management to come in at a weekend and "see for themselves how unsafe it is."

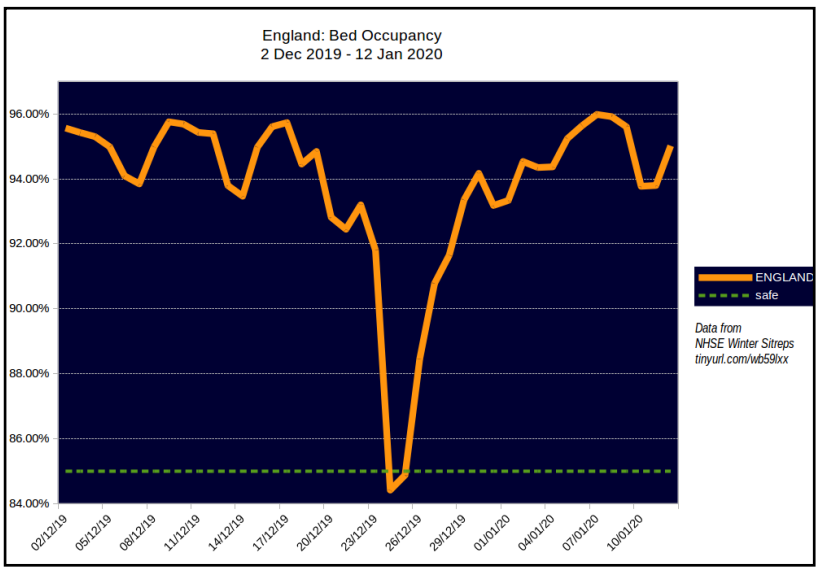
Her letter powerfully describes a situation which many A&E staff will find familiar:

"Your hospital is full – your A&E department is overflowing. But no further staff have been provided in A&E.

"You are concentrating on urgent treatment care and minors – this really is not the issue and if you continue to focus in this area someone will die.

"You are expecting staff to manage treble the number of patients in majors and resus that they would do normally, without breaks, this is not safe.

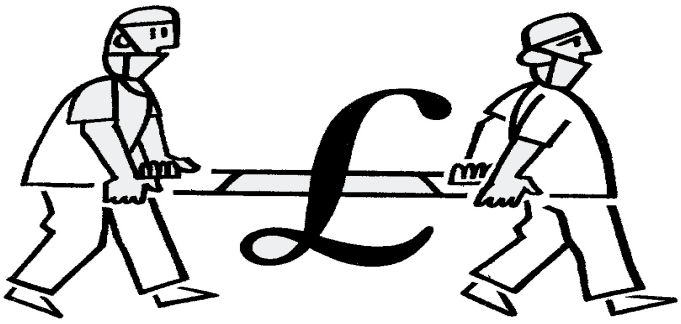
"They cannot provide that care – which is evident. The staff are trying their hardest and working to actual breaking point."



Graphs like this depicting performance for England and many of the regions are now available from Health Campaigns Together

This is a new feature in the Lowdown, in which we invite observers and campaigners to air their views on an NHS-related topic of their choice

Don't employ a politician



Guest column by ROY LILLEY

It's simple enough; you employ someone, they do a good job, a bad job, an indifferent job.

You keep them, sack them or train them.

It's not rocket science. It's the way of the world.

Harsh? Maybe. Perhaps there are reasons why someone doesn't do the job as well as you'd expect.

Lack of resource, training, opportunity, rules, regulations. Yup, I get that.

You're the boss and you have to fix it.

Yes, you are the boss and in this case, you are not running a business, you are an elector. You voted. You are running the country.

You have the outcome you like or don't like… that's democracy.

For the next five years you employ a government to keep the nation safe, care for the ones that have trouble caring for themselves and encourage us all to do our best.

Our money, your money, all our money employs members of parliament to run the nation.

What do we need to be fixed? What are the issues we want them to address?

I inhabit the world of the NHS. That's my locus. So, I want to see the MPs we employ, in the DHSC, fix some important issues. I could list about twenty mission critical things but, in the spirit of the first TV management guru, Sir John Harvey Jones; organisations should only concentrate on three things at once.

We need to solve three problems; social care, workforce and a safer NHS.

Let's have a look at them in turn.

The awful state of adult social care is a disgrace… probably a crime.

Local authorities, who have had their budgets shredded, in consequence, have raised their eligibility criteria for providing help, so high an Olympic pole vaulter couldn't get over the bar, never mind yer-granny.

There are 900,000 frail, vulnerable, elderly people, who used to get help, no longer do so. They wander around, like refugees, in our system and guess what? They pitch up in A&E, get transferred to a ward and stay there because no one can fund the care packages to get them home safely and timely.

I thought we employed MPs to fix that?

The obvious solution… we are all going to get old, so we all put a couple of quid in the tin. If we are lucky, we never have to take our couple of quid out of the tin. If we are not… there's money in the tin… don't worry.

It's called socialism. Don't be afraid to use the word. Community solidarity. You and me, looking after us.

We employ MPs to make sure we can look after us…

Workforce?

Neglect, underfunding, poor planning, the end of the training bursary for nurses… there's a list of reasons why we are in a mess. We don't have enough people to look after the people we need to look after.

Here's the big issue; there is a global shortage of care workers. A careful and thoughtful policy, to encourage qualified staff from outside the UK, to come and work here depends on a sensitive and sensible immigration policy.

A policy that is welcoming, creates opportunity, security and a future that is at least as good as the countries who are facing the same issues and have their policies sorted.

A training offer that makes working in the NHS attractive and rewarding, a reason for people to stay and the ones who have left, return.

We employ MPs to make sure we can resolve workforce issues.

A safer NHS?

No one comes to work in the NHS to do a bad day's work, to make an error, to be neglectful…

… but, a lot of people come to work and get distracted, frazzled, tired and make honest errors.

For fear of oppressive regulation, penalties and career annihilation, the errors get over-looked, covered up, ignored.

There is little learning from errors. There are few opportunities for NHS people to be frank about their actions or feelings. Why what happened, when it did.

We employ MPs to make sure there is a workplace environment that is calm, caring, supportive and a place to learn.

Three critical things and three opportunities for MPs to shine, make change, have ideas, innovate, and be supportive.

Three things that in my, over, 30 years in the NHS, the political classes have not delivered on.

Frank Dobson, when he was secretary of state for health, kicked a review of social care into the long grass. It's stayed there.

Successive health bosses have failed on workforce planning, and Jeremy Hunt, for all his bravado about a safer NHS, never dealt with safe staffing in the NHS.

Lack of resource, training, opportunity, rules, regulations?

MPs can change any of this.

If a barrier is too high, they can lower it. If training is needed they can make it happen. If regulations are too restrictive, they can change them. We employ MPs to do the people's work. Alas they don't.

For fear of party loyalty, electoral failure, criticism, challenge, making an effort, understanding or climbing the greasy pole.

The history is irrefutable… the moral of this story? If you want something done… don't employ a politician.

■ Roy Lilley's online newsletter carries comment and links to a wide variety of stories. Sign up here