The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

NHS imaging: national privatisation threat

Guidance recently issued by NHS England could lead to entire networks of diagnostic imaging services being run by the private sector.

NHS trusts have until 2023 to set up separate entities to run their diagnostic imaging services as part of a reform of diagnostic services. NHS England notes in the guidancethat the networks will be "significant operating businesses in their own right", and must have a "degree of autonomy" and "separation from the trusts".

NHS England has given the trusts seven options for setting up a network, one of which is "outsourcing" of the entire network to a commercial partner, this would include "ownership of the capital assets required for delivery of the service, to a commercial partner".

The other options are: collaboration or alliance contract-

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ing, which both rely on all trusts being involved with decision making; a "host trust" that would use delegated authority from other network members to make decisions; a joint venture with a limited liability partnership model; a joint venture through a limited liability partnership; or a community interest company (CIC). The joint ventures and the CIC would all need HMRC approval and only be possible for NHS foundation trusts.

Trusts are left to decide themselves what option is the best way forward, but NHS England has provided notes on the feasibility of each model. Only "Collaboration" between trusts and "Outsourcing" to a commercial partner get a "Highly feasible" note in the comparison table of the different options.

Demand outstrips resources

England's diagnostic services have been in need of reform and investment for many years. There has been a significant increase in demand over the last decade, with more attendances at A&E and more referrals from GPs. From 2014/15 to 2018/19 CT scanning increased 6.8% per year, MRI scanning was up 5.6% and PET-CT up 18.7% per year. There were also significant increases each year in other diagnostic procedures, including endoscopy.

Even before the pandemic the six week standard waiting time for a diagnostic procedure was being breached more frequently and since the pandemic there has been a significant increase in the number of patients waiting more than six weeks.

Lack of investment over the previous decade has led to the NHS in England lagging far behind the OECD averages for scanners (CT, MRI and PET-CT) per million population, ranking lowest among 23 countries for CT scanner provision and 19th out of 21 for MRI equipment.

Many NHS trusts have had to rely on charity efforts to buy large diagnostic equipment, such as MRI scanners. Charity appeals to upgrade MRI scanners currently live include ones at The Great Ormond Street Hospital and the Darlington Memorial and Bishop Auckland Hospitals.

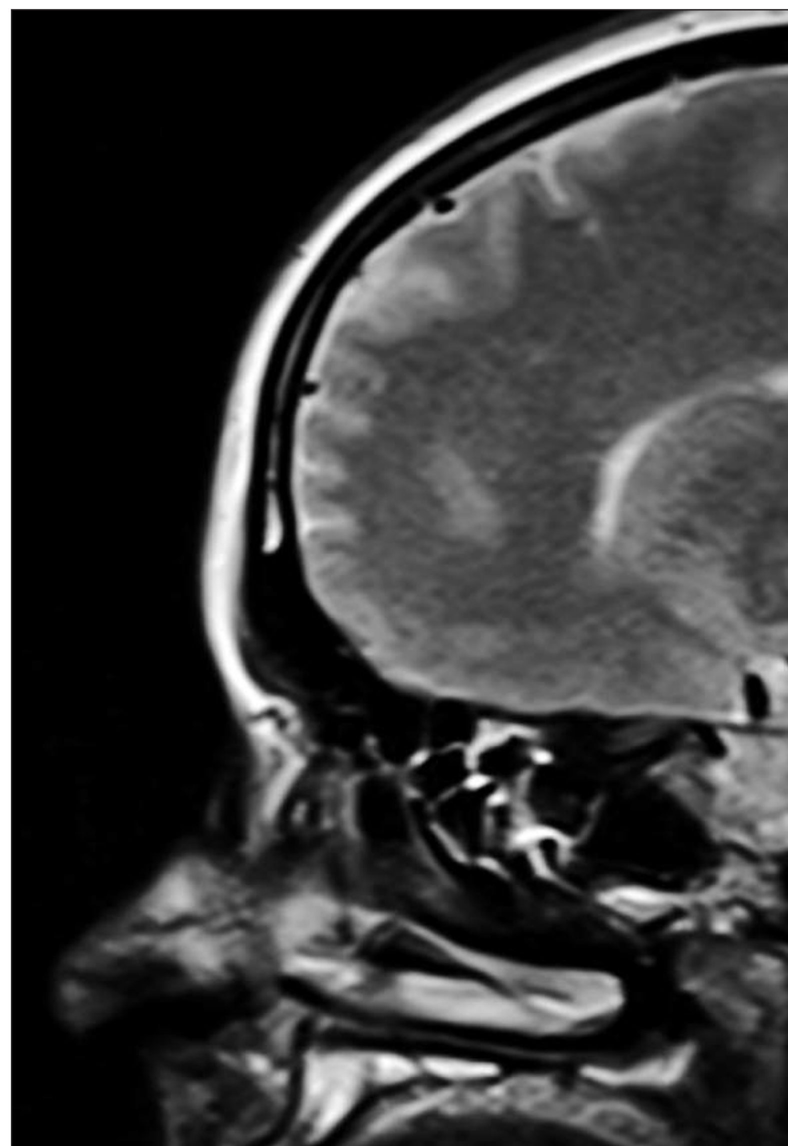
Following the publication of the Long-Term Plan in early 2019, which proposed the diagnostic networks as a way to decrease waiting time for scans and make more efficient use of staff, Professor Sir Mike Richards was commissioned by NHS England to review diagnostic services and make recommendations for reform.

The report, published in November 2020, had several major recommendations, including the setting up of community hubs where MRI, CT and other scans could take place in a Covid-19 free situation. However, a major component of the report is that major investment is needed if diagnostic services are to recover from the effects of the pandemic and the years of underfunding.

The report also recommends expanding the NHS's pool of scanners and other diagnostic equipment, such as buying in bulk to get good deals. However, it also notes that staff numbers are an issue and the training of additional highly skilled staff will take time.

Staffing too low

The problem of staffing is acute – according to the Royal College of Radiologists, England is short of 35% of radiology staff and needs at least another 1,613 full-time consultants to keep up with safe staffing quotas and the demand for scans, but at the current rate, the RCR, note that the workforce will only increase by 571 consultants over the next four years.



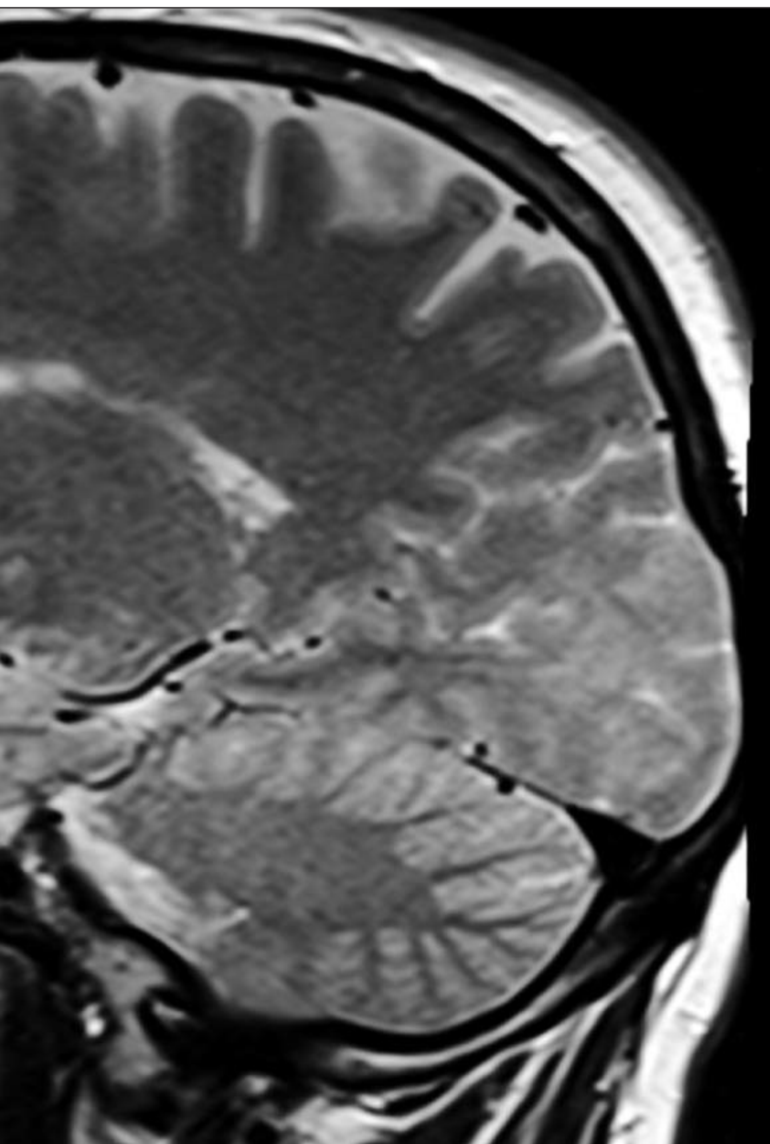
The RCR report is based on census data from December 2019 before the pandemic and shows how the services were struggling, with the majority of hospital imaging managers stating that radiologist shortages were threatening patient safety.

During the past decade of underfunding, instead of investing in replacing old equipment and buying new equipment as demand increased, NHS England, CCGs, and NHS Trusts all sought to expand capacity by paying private companies for diagnostic services. As a result, over the years, private companies have become firmly embedded in the system.

A history of outsourcing

In the NHS Support Federation's annual review of privatisation in the NHS, diagnostics services were often in the top three services outsourced by contract number.

A good example is the two phase procurement procedure for PET-CT diagnostic imaging services begun in 2014. In late 2014, NHS England selected the Molecular Imaging Collaborative Network (MICN), led by the private company Alliance Medical, to provide PET-CT scanning services across 30 locations in England – the company now provides services over much of the North of England, the Midlands and Eastern England under this contract. The contract is for 10 years and was valued at £350 million. As part of this contract, in July 2020 Alliance Medical opened a new digital PET-CT unit at Queen Mary's Hospital, Sidcup, in partnership with Oxleas NHS Foundation Trust.



The phase II round of procurement in 2018 gave a large contract to InHealth in the Thames Valley.

Private companies are also listed on a number of framework agreements covering many aspects of diagnostic services, such as teleradiology services, endoscopy, andMRI scans. The most recent is the November 2020 framework contract NHS Increasing Capacity worth in total £10 billion, which runs until November 2024. This covers both elective surgery and diagnostics. Included on it are companies, such as InHealth, Alliance Medical, Medical Imaging Partnerships Ltd and Mediscan Diagnostic Services.

In community health, many CCGs have for several years outsourced diagnostics to private companies. InHealth alone has 100 community diagnostic sites across the country where patients are sent for diagnostics by their GP under agreements between the company and CCG. One such agreement was signed in March 2019 by NHS Ealing with InHealth to provide community radiology services.

Private companies embedded

The guidance given by NHS England seems to take a somewhat simplistic view of the different options for creating a diagnostic network. The extent to which the private sector is embedded in the NHS will make for complications. For example, what will happen to the scanners paid for by charity appeals if the hospital trust decides to give these assets to a commercial partner.

In February 2021 it was widely reported that the leaked government white paper contained plans to do away with competition in the NHS. This was interpreted by some to mean also a move away from privatisation. This new Guidance from NHS England, however, shows that privatisation is still an approved and feasible option that NHS trusts can take.

The level to which the private sector is already embedded within the diagnostics sector, might well now tempt NHS trusts to take the "outsourcing to a commercial partner" option leading to complete privatisation of large sections of diagnostic services in England.

Stevens heads for the exit before new systems fail

The latest, shocking statistics show the scale of the decline of NHS performance on almost all of its key targets: but the NHS was floundering BEFORE Covid-19 struck last year.

It needs more staff and more funding to run services, and capital to tackle backlog maintenance and refurbish and re-plan buildings to reopen beds closed during the peak of the pandemic. But questions must also be asked about the senior management of NHS England and its soon to depart chief executive Sir Simon Stevens.

Stevens' announcement he is to stand down in July has triggered a sharply divided response, ranging from the brickbats of those who believe him to be the evil genius plotting to privatise the NHS, to veneration from fans who see only positives in his record, including crediting him with delivering extra cash, the Covid vaccination programme, and beginning to roll back Andrew Lansley's disastrous 2012 Health and Social Care Act.

But if his fans give him credit for what has worked well, Stevens and the team around him must also share the blame for the decline in performance of NHS services since he took the top job in 2014. Had Stevens, a former Labour councillor and advisor to Tony Blair's government, performed on a similar level as manager of a Premier League football team or many private businesses he would have been out on his ear several years ago.

He took over at NHS England after working nine years as a

vice president of US health insurance giant United Health. Six months later he published a major policy document, the Five Year Forward View (FYFV).

Looking back at the 44-page FYFV is like stepping into a museum: most of the key commitments have long ago been sidelined or reduced to token gestures, not least the insistence that:

"The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."

In fact as the Covid crisis has brutally exposed, since 2014 we have seen year after year of cuts to public health budgets which are supposed to fund schemes to help tackle obesity and reduce consumption of alcohol, drugs, and tobacco. This is not Stevens' fault: but what is his fault is that his plan rested on such unrealistic assumptions.

Many of the main FYFV ideas, whether people agreed with them or not, have also remained little more than words. For instance patients were to be given control over shared budgets for health and social care – a controversial idea with many campaigners. It also lacks sound evidence that it can work in the NHS. Stevens in a July speech in 2014 suggested "north of 5 million" such personal budgets might be operational by 2018, sharing £5 billion between them.

Personal budget shortfalls

But this would have meant average payments of just £1,000 per year, £20 per week – well short of the amount required to secure any meaningful care package for any but the most minor health needs. In fact the latest figures show fewer than 89,000 people were receiving personal health budgets at the end of 2019 – a long way short of 5 million.

Carers, too, were promised new support by the FYFV: but the plight of carers remains desperate, with increased misery for many of them hit by the succession of welfare cuts and the nightmare of universal credit – with never a word raised on their behalf by NHS England.

According to the FYFV, barriers between GPs and hospitals, physical and mental health and health and social care were going to be broken down, with a shift of investment from secondary care into primary care. A "Forward View" for GPs was indeed published: but there it stopped. The under-funding continues, and the barriers are still intact. Overworked, under-staffed GPs face ever-increasing demands, with no sign of the promised increase in numbers or resources.

The FYFV also made bold promises to invest in more staff and improved services for mental health. Predictably none of these things have happened. Instead there are still thousands fewer mental health nursing staff now than there were in 2010, and the performance on almost every measure is as bad or worse than 2014.

After such a comprehensive failure to deliver almost any significant element of the FYFV, and the equal failure in 2016 to develop credible Sustainability and Transformation Plans, the likelihood of making the 10-year Long Term Plan (LTP), published in January 2019, any more than a wish list or a pious declaration was vanishingly small.

Negatives outweigh the positives

The Long Term Plan did contain a few positive concessions to the pressure of campaigners and the needs of patients:

- New waiting time targets are to be introduced for adult and child mental health – although these are far from ambitious and without extra funding imply cutbacks elsewhere
- A promise of action to address unexplained mortality for people with learning disability and autism and the long waits they experience
- No explicit call to close acute hospital beds
- The idea is floated that the NHS take back responsibility for some public health provision

These few positive elements must not distract us from the hard proposals in the LTP for a further top-down reorganisation of England's NHS – into a centralised structure of 42 "Integrated Care Systems" (ICSs) within two years.

The Plan, now supplemented by the recent government White Paper required a series of mergers to reduce from 191 Clinical Commissioning Groups to just 42 ICSs from next April.

Tucked away in the LTP are more hard-edged proposals for increased use of private hospitals to deliver NHS funded care to limit waiting times. That was already being surreptitiously driven through by NHS England before receiving a massive boost during the Covid pandemic from the billions spent block-booking private hospital beds – and now the £10bn framework agreement for private hospitals to treat NHS elective patients over the next four years.

Threat of privatisation

The LTP also put pressure on trusts to increase their links with the private sector to "grow their external (non-NHS) income" and "work towards securing the benchmarked potential for commercial income growth." We can see evidence of this in new plans by major trusts such as Oxford University Hospitals and the Royal Marsden to prioritise expanding their private patient income even while NHS waiting lists are growing.

There also is an implicit threat of privatisation in the LTP proposals for new pathology networks and imaging networks to be established, in the absence of the necessary NHS capital for investment.

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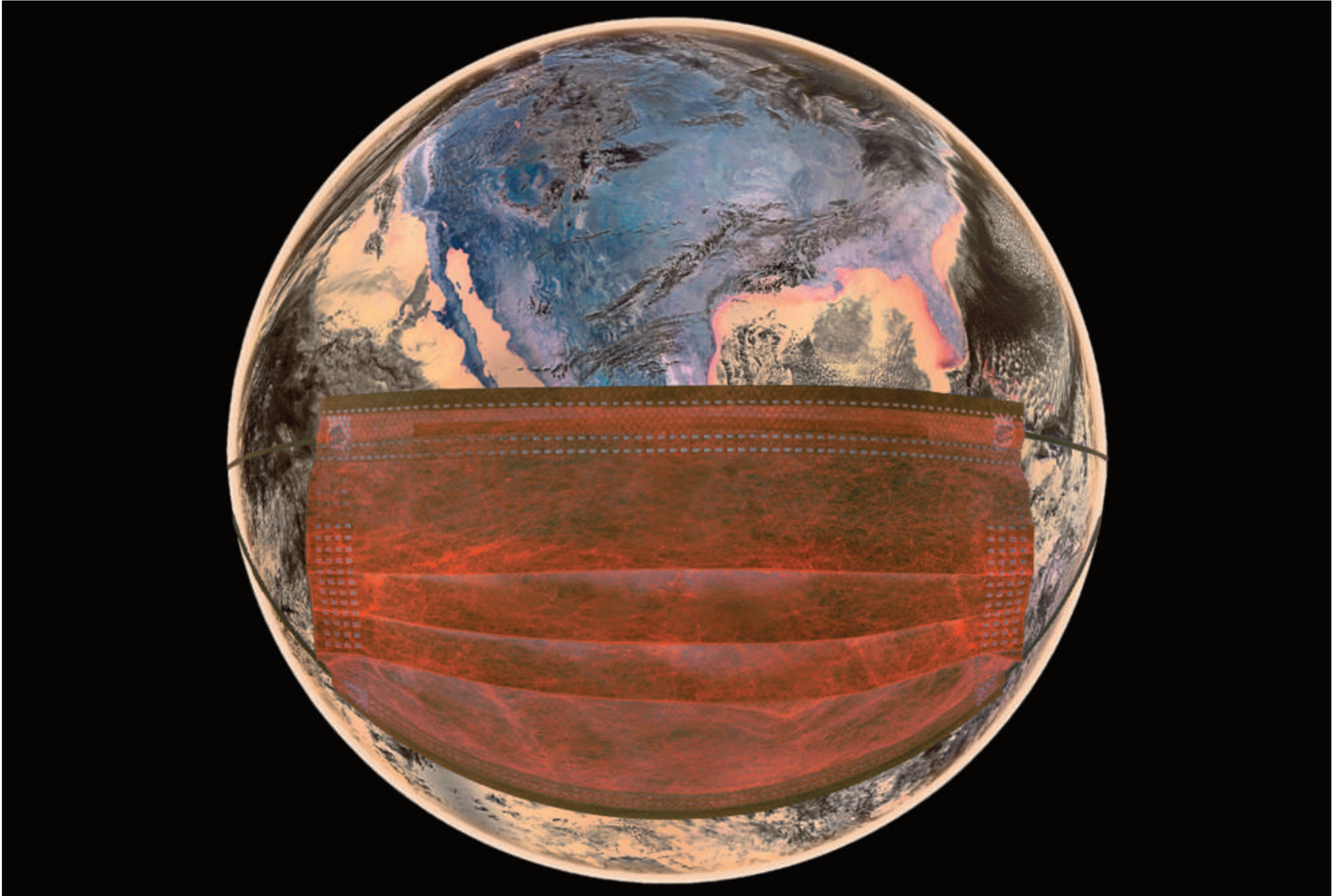
The NHS' carbon footprint – is enough being done to reduce it?



With the UK hosting the UN climate change conference Cop26 later this year, it's perhaps timely to look at how the NHS – historically said to be the country's biggest greenhouse gas emitter – is trying to do its bit for the environment.

Given that it employs 1.5m people and accounts for more than 7 per cent of GDP, it's perhaps no surprise that the health service is also responsible for around 7 per cent – ie roughly 25 tons of CO2e – of the national carbon footprint each year. That's higher than the global average of just under 5 per cent, and roughly equivalent to the total carbon emissions from Sri Lanka.

These figures for the UK do in fact represent a 26 per cent reduction from 1990 levels, a major feat as over the past three decades the NHS has actually experienced a doubling of single inpatient admissions. That means that the 'carbon intensity' of services per patient has in fact decreased by 64 per cent.

But the health service still has a way to go if it's to play a part in helping the UK nationally meet its 2019 legislative pledge to achieve 'net zero' emissions of greenhouse gases by 2050.

Many of the environmental challenges are unconnected with the crumbling NHS estate, which accounts for just 20 per cent of the health service's carbon footprint [02], although healthcare settings remains crucial. An average GP appointment has a much lower CO2e footprint than an elective inpatient stay, for example.

'Care miles' are a major factor, with more than 9.5bn NHS-related miles (by staff, patients and visitors) being travelled a year in England – one in every 20 road journeys is said to be healthcare-related.

Largely down to supply

Supply chain issues account for most (more than 60 per cent) of the NHS' footprint, however, and revolve around pharmaceuticals and anaesthetic gases (the latter representing 5 per cent of acute hospitals' emissions), as well as medical and non-medical equipment.

Simple solutions like switching from hydrofluorocarbon-dependent metered dose inhalers – ie 70 per cent of those prescribed by the NHS – to dry-powdered inhalers, for example, would reduce total NHS emissions by 4 per cent, it has been claimed.

NHS England chief executive Sir Simon Stevens has certainly attempted to address the health service's carbon footprint over the past 18 months. He flagged up a new initiative last year, just as the pandemic was about to break, with two developments: firstly with the launch of the 'greener NHS' programme in January – which built on the NHS Long Term Plan's 'digital first' commitment to better use technology so that 30m outpatients appointments could be made redundant.

Aiming for zero tolerance

He followed this up in October with the publication of the 'Delivering a Net Zero National Health Service' report. This echoed the 2019 parliamentary pledge with two "clear and feasible" targets for the NHS, potentially making it the world's first health service to commit to net-zero emissions:

– reducing emissions controlled directly to net zero by 2040, with an ambition to reach an 80 per cent reduction by 2028 to 2032

– reducing emissions the NHS can influence to net zero by 2045, with an ambition to reach an 80 per cent reduction by 2039

Admirable though these aims may be, Stevens is now stepping down from his chief executive role, so it's presently unclear what impetus remains to take them forward until his replacement is appointed later this year.

And, targets aside, it's also unclear – when the NHS is under such pressure during the pandemic – how genuinely useful road-testing the 'world's first zero-emission ambulance' by 2022, completing a £50m LED lighting replacement programme or supporting the alleged construction of 40 new 'net zero' hospitals with a 'net zero carbon hospital standard' (all highlighted in the report as 'early steps' towards net-zero status) will be in achieving the report's aims.

Purchasing power

Subsequent analysis by the LSE's Grantham Institute highlighted the potential for the NHS to wield its considerable purchasing power – it procures materials from 80,000 suppliers – to influence change by excluding firms that do not aim for zero carbon. But it also pointed up how the report missed the potential role of preventing ill health, and thereby mitigating emissions through reducing hospital admissions and treatments. It is estimated that the NHS spent £6.1bn on overweight and obesity-related ill-health alone in 2014-15, equivalent to the annual spend on the police, the fire service and the judicial system combined.

Backing up the Grantham Institute's assertion that the NHS should be weaponising its procurement muscle to counter climate change, only last month a Royal Society of Medicine/Brighton and Sussex Medical School report noted the huge amount of PPE – about 3bn items – used in the first six months of the pandemic had added an extra 1 per cent (106,000 tons of CO_2e) to the UK's carbon burden, with many of the items shipped from China, Thailand and Malaysia rather than manufactured in the UK, adding greatly to the environmental cost.

Meanwhile, details recently emerged of plans to extend the existing contract to manage NHS England's Integrated Single Finance Environment (ISFE) – run by NHS Shared Business Services (a joint venture between the Department of Health & Social Care and French software consultancy Sopra Steria), and overseeing all the NHS' procurement responsibilities as well as HR, payroll and finance – by three years, up until March 2024.

This is because planning for a new financial system was delayed by the outbreak of covid-19, and a tender for the new contract will now be published in July – coincidentally just as Sir Simon Stevens steps down from his as NHSE chief executive.

The ISFE is currently used by commissioning bodies "to administer their financial key management and statutory obligations", and it will be interesting to see whether the tender for its replacement reflects the NHS' net-zero aspiration regarding procurement in any way.

Encouragingly, current contractor Sopra Steria describes itself as "a major player in the fight against climate change", and last year committed to achieving net-zero emissions by 2028.

Genuine progress?

No-one knows what long-term impact Stevens' net-zero initiative will have, or whether the targets he set will ever be achieved, but it's worth looking back to comments made by the King's Fund about another Stevens-backed initiative, the Long Term Plan, in 2019. The thinktank noted that, despite the carbon footprint of NHS England having fallen during the previous decade, the combined negative impact of austerity, Brexit and the 2012 Health and Social Care Act had resulted in a 'tyranny of now' scenario, with the term 'sustainability' in the NHS more often referring to financial rather than green issues.

That approach is sadly still in evidence today, with Cop26 fast approaching. The White Paper on the future structure of the NHS, unveiled with great fanfare by health secretary Matt Hancock in February, and which forms the basis for a Bill to be set out in the Queen's Speech later this month, barely mentions a green agenda at all.

Martin Shelley

Unfortunately, hospitals can make you unwell

Health journalist Mike George explores his own experiences of lengthy treatment in the NHS and how we can improve the patient outcomes:

In these Covid times we're seeing a lot more people than usual having to receive hospital treatment and care for a while, and in some cases for a long while. There are also likely to be an increasing number of patients discharged into the community with, often complicated, long Covid conditions. How well or badly these people fare healthwise will of course depend in large part on the quality of care they receive while hospitalised.

During 2020 I was in three hospitals for three and a half months in all with a complicated and rather hard to pin down medical condition. This was followed by a period of over 3 months when I was still not at all well, though I'm just starting to get better now. I can appreciate that the various doctors involved in trying to find out what was wrong with me and making me better used their professional expertise with diligence and care. Even so, when I was at last discharged I left with anaemia, pressure sores, mood swings, numbness and more.

So how and why had my hospital stays made me so unwell? Luckily my wife had found some literature on how long hospital spells decondition patients. This overarching concept rang true with me. Basically, hospital-acquired deconditioning occursbecause enforced bed rest, immobilization and sedentary behaviours can cause temporary or permanent and irreversible functional decline, especially among older people. This is most easily seen in muscle wasting and loss of physical strength, but it can impact pretty much on any aspect of bodily functioning and, of course on mental health.

Pyjama paralysis

I recall that during my hospital stay I was always wanting to walk more, and no, this problem did not just arise as a result of Covid restrictions inside hospital premises and in the community. For example, before these Covid times the End Pyjama Paralysis campaign was pushing NHS England and other organisations to get patients out of hospital beds, into their own daytime clothes, and walking onwards.

Deconditioning can also lead to obvious problems like an increased risk of falls, catching hospital bugs, and to the onset or worsening of confusion or delirium. For example, I had two falls in hospital which, unnervingly, led to even greater restrictions on my ability to move. One was caused by the effects of my reduced

core strength (thanks to deconditioning), the other by an episode of dizziness caused by a temperature spike. Annoyingly the second one resulted in me falling onto a badly placed metal filing cabinet near my bed and cutting my arm open in the process, it also led to the onset of pain and numbness in most of my toes for some reason!

On the rails

Another disabling hospital practice is how bed rails are used in practice by hospital staff. These rails can be impossible to adjust in any way if you are a patient in bed, they can also make it impossible to reach your phone or glass of water for example. Obviously, they have a crucial safety function, but I still question how they are used in practice. I also became all too aware of the importance to the patient of being able to access their own bits and pieces like toothpaste, watch, shaver or comb. I was disturbed by the fact that that these and other personal things had often been misplaced or moved, and I was impressed by just how important these supposedly little things were.

I was also surprised by how upsetting it was to have no consistent access to drinking water. I'd been told frequently that I had to drink more. For instance one doctor told me that I had postural hypotension; this is basically dizziness when sitting up or standing caused usually by medications and dehydration. But despite my repeated pleas to healthcare staff for bottles or cups of water that I could reach, I found frequently that I had use the call button to try to summon someone to get me some water. Only slightly less important in my view were the problems I came across in trying to keep my phone charged; regular phone calls to my wife were of fundamental importance. Other seemingly small things that turned out to be rather important include being able to clean your teeth properly and in a timely way, being able to get some exercise safely, having some sort of view to greenery, and even getting your hair and nails trimmed. Keeping your personhood intact may be tough for those in hospital for a while but I found that it's vital for people's physical and mental health. After all, leaving hospital in a deconditioned and depressed state is surely sub optimal, to say the least.

No mental stimulation

What else made me unwell? I was perfectly aware that I wasn't in hospital to have fun but I found that the lack of stimulation worsened my mental state; I came to consider trips to the X-Ray department for example to be a treat. No televisions, dodgy radio reception, and only intermittent online access didn't help, particularly as we weren't allowed visitors, and in the main ward staffs weren't happy about this either. Incidentally, I was struck by how isolated most older men were. The over 80s in particular seemed unhappy and resentful about not having their own mobile phones or about not being able to use them. These difficulties were thrown into stark relief by the joyous release felt by most of us inmates at having regular visits by volunteers. In my case, volunteers found personal possessions for me, helped to make sure that my devices were charged, and of course they provided much needed opportunities to chat – about anything really. This is not to diminish the input of nursing and other healthcare staff, but I found that in general they did not have the time to attend to all the many needs of us patients.

No account of the elongated time spent in hospital can be complete without the obligatory complaint about food. Sadly, after all these years of campaigns, the appointment of food tsars and the rest, one must still complain. For in my experience the outsourced food I was given was far too often pretty disgusting, often lukewarm, and not even that good for you. Like exercise and access to drinking water this basic requirement always seemed to be someone else's responsibility, In this case I assume that the person or persons responsible were those who chose the catering firm and agreed the terms of the contract. Consequently I lost a lot of weight, despite being told often that I had to put weight on in order to protect and improve my health! An absurd situation, if it hadn't been so serious.

Finally, it hardly needs saying that if we are discharged from hospital while still unwell, the chances of us being able to recover in an effective and timely manner are reduced drastically; but it seems that it does have to be said. Being very weak and unwell ill at discharge is very hard on patients, their families and carers, and on health and social care staff in the community. The importance of hospital care stretches well beyond hospital gates – can someone tell the hospital trusts about this please.

References to support this article can be found online at: https://lowdownnhs.info/comment/unfortunately-hospitals-can-make-you-unwell/

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Failing to deal with failure: NHS England has another try

The NHS has come full circle and started round again on its efforts to deal with trusts and commissioners that display clear signs of failure to deliver financial stability, or safe services of sufficient quality to satisfy the CQC inspectors.

Back in 2005-6, at the high point of New Labour's embrace of the idea that competition, private contractors and markets could be the key to improving NHS services, and when 190 NHS organisations were carrying deficits, many of them for year after year, then Health Secretary Patricia Hewitt set up a National Programme Office to drive through "turnaround" measures.

A standard response would be to wheel in costly management consultants to lead "turnaround," but options were limited for tackling large scale financial problems: as a King's Fund study pointed out:

"The result all too often is that some reduction in the deficit is achieved at the cost of deterioration in the quality of patient services and distraction from achieving greater productivity improvement over the medium term."

Special powers

As the deficits continued and in the aftermath of the banking crisis, the 2009 Health Act introduced a 'Failure Regime' to deal with trusts that could not balance their books. It provided for the appointment of a trust special administrator, working to a tight timetable allowing little or no local consultation, to advise the Secretary of State on what action should be taken when a trust fails.

This was not used until 2012, when it was invoked to take special powers to dismember the floundering South London Hospitals Trust, which was swamped with debt from two disastrous PFI hospitals. This intervention resulted in the long (ultimately successful) battle against the trust special administrator's plan to include major cutbacks in the neighbouring Lewisham Hospital Trust in a major reorganisation.

Then in October 2012 the Foundation Trust regulator Monitor for the first time intervened on safety grounds, and invoked its own failure regime to address the revelations of scandalous failures in quality of care in Mid Staffordshire Hospitals Foundation Trust.

Successes, not failures?

Both of these interventions triggered major campaigns and had long term negative consequences. This may be why following on the Five Year Forward View in 2014, new NHS Chief Executive Simon Stevens argued in 2015 it would be a better idea to deal with failing trusts not with a failure regime but a "success regime," which would address both financial and clinical failures.

It was to be new in combining intervention with support to the local system in trouble, and unlike previous 'special measures' it was not subject to a strict time limit. Three areas, North Cumbria, Essex, and North East and West Devon, were chosen as the first to be subjected to the success regime in June 2015. In Cumbria and Devon management consultants were brought in at great expense.

However six months later the success regime became entangled with the establishment of Sustainability and Transformation Plans, with the result that little of substance was achieved.

UNISON's Eastern Region newspaper Eastern Eye in October 2016, noted the reluctance of the Essex success regime to engage with trade unions, while appointing a new 'HR Transformation Manager', tasked with developing a "flexible workforce that can work across organisations and geographical boundaries," summed up:

"It may be a bit early to brand the success regime a failure: but its main successes so far are confined to creating new management titles and posts."

Over four years later there is still little evidence that the success regime has delivered any benefit: but STPs have come and gone, and now Integrated Care Systems are the latest panacea for the under-funded, under-staffed NHS. ICSs (which

as yet have no legal standing) are not covered by existing remedial measures, and separate systems have applied to trusts and CCGs. NHS England argues the new regime will cover providers and commissioners:

"Having these separate programmes no longer fits with the much more integrated approach to healthcare and it is now time to focus on an integrated system approach to improvement."

So in place of the "success regime" NHS England/Improvement have now unveiled a new "oversight framework," setting up a 4-segment system allowing intervention intofailing trusts, CCGs or ICSs.

The new default setting is that all trusts, CCGs and ICSs will be put into segment 2: the best performing of them can request promotion to segment 1, where they will be subject to minimal oversight. Trusts in segment 1 will be exempt from limits on spending on consultancy and running costs, and "benefit from streamlined business case approval." Similar "autonomy" will also be available to segment 1 ICSs and CCGs.

By contrast providers and commissioners with problems can be pushed down to segment 3, where they will be required to accept "formal intervention and mandated support," while those with the most serious problems could find themselves dumped into segment 4, and subjected to "mandated intensive support … delivered through the nationally coordinated Recovery Support Programme."

Grounds for relegating a trust to segment 3 include performance on key measures in the bottom quartile nationally – suggesting up to a quarter of trusts could be included; "a dramatic drop in performance, or sustained very poor (bottom decile) performance"; financial failure" reporting a negative variance against the delivery of the agreed financial plan and/or it is not forecasting to meet plan at year end;" or for failures of quality highlighted by the CQC..."

John Lister

...this article is ontinued online at: https://lowdownnhs.info/analysis/failing-to-deal-with-failure-nhs-england-has-another-try/

Scientists plan strike after Lancashire trust reneges on pay

Biomedical scientists, who have been on the frontline of Covid-19 testing at a Lancashire NHS trust, will stop doing night, weekend and late shifts as part of a month-long strike action after 'bad faith' by bosses who reneged on an upgrading pay agreement.

Unite the union warned that the impact could mean the accident and emergency department at the Royal Blackburn Hospital will close at night and weekends.

Unite said that its 21 members working for East Lancashire Hospitals NHS Trust were owed back pay of between several hundred pounds to £8,000, as managers had failed to honour an agreement to upgrade them from band 5 to band 6 on the Agenda for Change (AfC) scale.

The back pay issue goes back as far as 2010 for some members.

Now the scientists, who analyse patient blood samples at the Royal Blackburn Hospital and the Burnley General Teaching Hospital will strike continuously from Friday 7 May until Friday 4 June, after they voted by a majority of 85 per cent for strike action.

This will mean that they will only work on their core days – Monday to Friday from 08:45 to 17:00 and early shifts on core days (Monday to Friday) from 07:00 to 15:00.

They are also contracted to work night, weekend and late

shifts – but they will be striking during those times.

Unite regional officer Keith Hutson said: "Our biomedical scientists, who have had years of training and are highly skilled, have voted overwhelmingly for strike action which will adversely impact on how quickly patients' samples can be analysed.

"It may mean that the accident and emergency department at the Royal Blackburn Hospital will have to close at night and weekends and ambulances with patients sent to other hospitals across the region, as there will be no one on duty to analyse samples. (Burnley General Teaching Hospital does not have an A&E department)."

"Now is the time for the trust management to do the right thing before strike action starts – Unite's door is open for constructive talks at any time."

JL

...continued from page 5

To sugar the pill, the Long Term Plan has to say something and so it rattles out upwards of 60 uncosted commitments to improve, expand or establish new services. Most of them, if taken at face value would be most welcome – but taken together in this context they are completely unaffordable, unrealistic and incapable of implementation.

There is promise after promise, many of them sounding great: prompt response services, proactive care, flexible teams, neighbourhood teams, primary and community care teams, community multidisciplinary teams and upgraded support. All these are presented in happy-clappy, completely abstract terms, without explaining how they were chosen, who would be responsible, or the timescale for implementation.

The Long Term Plan is a medium term threat to the services we all depend upon – and our ability to find out what's happening and fight back locally to defend the services we need. With financial constraints limiting any real improvement, and a new system being imposed from top down and accountable only upwards to NHS England, patients and the public will have less voice and influence than ever in the shape of services and their access to them.

But if Simon Stevens has, as some believe, been an agent for US health corporations as part of a conspiracy aiming to "Americanise" the NHS, there is little sign the conspiracy is succeeding.

Centene is the only US health corporation to have made any substantial attempt to win contracts to deliver health care, buying up a network of profitable GP practices, but stopping short of bidding for hospital services. No other US health insurers have made any serious effort to set up in the UK, although some are keen to market their digital expertise, seeking lucrative but relatively small scale back office roles in the NHS.

In the US the data-driven techniques of "Accountable Care Organisations," like similar experiments in England, lack evidence that behind the hype they can limit demand for care, deliver any significant benefit to patients, or save any significant money.

It's worth noting Stevens is heading off to the House of Lords before these same methods are tried out in earnest (and at far greater expense) in Integrated Care Systems from next April. That means he can play a role in pushing through the coming Bill to give them legal status, but will not be around to take the blame when they fail to deliver any of the claimed benefits.

Stevens' record in charge has been one of consistent failure masked by the rhetoric of grand, impractical plans, few of which have been more than partially carried through. He has proved to be neither the villain some feared nor the saviour of the NHS others hoped.

Praised to the skies by the Health Service Journal for 'saving the NHS' on three occasions, and as "the greatest strategic health policy thinker of his generation," it's true that Stevens cannot be held to blame for all of the failings of the NHS that stem from under-funding and government policy.

But the fact is that he leaves an NHS weaker than it was when he took over, with far greater dependence and higher spending on private providers. He also leaves a vacuum of leadership which could yet be filled by another Tory stooge or crony bad enough to make us regret his departure.

John Lister

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