The lowdown

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

Is 'step four' a step too far for the NHS?

The move by the government to trigger step four of its 'roadmap' back to pre-pandemic normality, confirmed today in the House of Commons by health secretary Sajid Javid, is set to have a disastrous knock-on effect on A&E attendances, hospitalisations and waiting lists, just as the NHS is struggling to deal with a rapid rise in covid infections.

With hospitals now reporting 'black alerts' and 'major incidents' year-round, and waiting lists set to reach 13m within months, the move to relax most covid restrictions in England on 19 July – a date breezily marketed to the public as 'freedom day' – will further undermine an understaffed and underfunded health service that is already close to being overwhelmed by the pandemic.

One of the most dangerous elements of the move con-

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cerns mask-wearing in healthcare settings such as hospitals and care homes, which now appears to be only optional under step four. More infections, including among NHS staff, are sure to follow as a result.

Vaccines minister Nadim Zahawi told Sky News on Sunday that the public would simply be "expected to wear masks indoors in enclosed spaces", rather than be required to, while Javid told the Sunday Telegraph that people would merely be "irresponsible" if they refused to wear masks in enclosed spaces.

The impact of this laissez-faire approach is already being seen, with doctors complaining that patients are coming into hospitals thinking they no longer have to wear masks at all. One medic told the Guardian, "We are [now] inviting the virus to spread among the very people we need to protect."

And a heavy hint of how this 'return to normal' strategy could backfire and harm the NHS was very much in evidence last week, with news of covid vaccinators facing verbal and physical abuse, especially from younger adults demanding second jabs early just so they can go on holiday this summer. In some cases staff had to call the police, in others security guards had to be hired – probably not what the government intended when it devised its 'Protect the NHS' slogan last year.

One report suggested this behaviour has been driven in part by the government's questionable decision to allow double-jabbed Brits to return from amber-list countries without having to quarantine – another element of the 'freedom day' plan.

Infections rocketing

Meanwhile, HSJ tweeted today that the number of covid-positive patients in English hospitals has risen by 48 per cent in the past week alone, to 2,798, a rate of increase not seen for nine months. The total number of new cases recorded last week in the UK was up 34 per cent on the previous week – passing 32,000 for the first time since January – as was the total of confirmed and probable case numbers for the Delta variant. Last week also saw the highest daily increase in lab-confirmed covid cases since 22 January.

The ONS said the percentage of people testing positive for covid has increased in all regions in England, and across all age groups. Backing up these figures, the covid reproduction number – the R value – has risen to between 1.2 to 1.5, meaning the outbreak can grow exponentially, and is now increasing by up to 7 per cent every day. And Imperial College London's React study found a quadrupling of new infections in England between mid-May and early July.

Despite Downing Street's protestations that vaccinations have broken the link between covid infections and hospitalisations, A&E and elective surgery statistics nevertheless continue to show the growing impact of the pandemic.

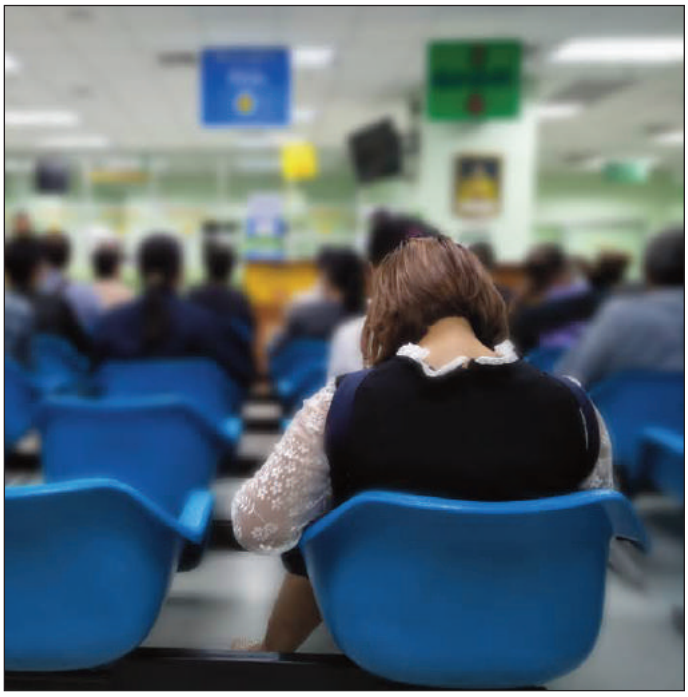
Highest-ever A&E numbers

Attendances at 24-hr A&E departments (described by NHS England as 'type 1') last month were more than 40 per cent higher than in June 2020, signifying the highest-ever number since this type of data was collected. Emergency admissions via type 1 departments were up by more than 20 per cent since a year earlier. Across all A&E services, there were more than 2.1m people attendances, making it the busiest-ever June.

As for the waiting list backlog, analysis of NHS England figures by HSJ last week showed the number of patients waiting more than two years for elective care grew by almost 50 per cent in the space of a month. The waiting list in England broke records for the second month in a row, and has now reached 5.3m.

Last week Leeds Teaching Hospitals NHS Trust had to call off some planned non-urgent operations, including cancer surgery, to help it cope with an influx of patients seriously ill with covid, and Birmingham's Royal Orthopaedic Hospital also had to postpone planned elective surgery because so many of its staff were off work while in quarantine.

In fact NHS staff, as well as elective patients, seem very much an afterthought in the government's preparations for 19 July. Downing Street's failure to address the issue of pay,



at a time when many nurses and hospital doctors are suffering from burnout and are justifiably terrified of the consequences of moving to stage four, is something of a national scandal. This indifference prompted a new pay campaign by Unite last month, and both the BMA and the Royal College of Nursing are now considering industrial action in protest at this 'slap in the face' situation.

The only response from Number 10 on the topic of staff shortages, likely offered solely because these shortages have played a role in the cancellation of elective surgery, came a few days ago – a suggestion to allow fully vaccinated nurses and doctors to forgo immediately the obligation to self-isolate when 'pinged' by the NHS covid app, rather than wait until 16 August when everyone double-jabbed can do so.

Massaging the figures?

That specific relaxation – dropping the need to self-isolate when fully vaccinated – touches on a related move flagged up last week, ostensibly designed to make people's lives easier and to 'protect the NHS', but hinting at a ploy simply to hide the numbers.

With the sharp rise in cases already overstretching local testing capacity, the threat posed by the wholesale lifting of covid guidance and restrictions on 19 July has led one public health director to suggest testing may have to be rationed because the case numbers are rising so rapidly. One sign of this happening is the 62 per cent increase in the number of people 'pinged' by the NHS covid app in the last week of June, advising them to self-isolate.

Unsurprisingly, many users of this app are said to be ditching it to dodge the need to self-isolate in the run-up to 19 July. In a move designed to address this problem, last week UK Health Security Agency head Dr Jenny Harries revealed that the government was considering 'adjusting' the app, effectively cutting the numbers being told to isolate.

Labour leader Keir Starmer dismissed this move, describing it as "like taking batteries out of a smoke alarm", and news of the app revamp came as vaccine uptake almost halved in early July, a major concern for the NHS given the increasing awareness that ICU cases involving unvaccinated people are on the rise.

The government's decision to press on with the move to step four while the data suggests caution – no-one in the Cabinet seems to remember the 'data not dates' slogan – has justifiably been panned as premature, if not ill-advised, by leading voices in the NHS and elsewhere.

The BMA has urged the government to reconsider its plans, and wants mandatory wearing of facemasks in enclosed indoor public settings to remain. Its council chair Chaand Nagpaul said last week, "We now have twice as many people in hospital and on ventilators compared to a month ago. Even

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Maternity safety compromised in a third of NHS trusts

An increase in funding of £200-£350 million per year is urgently needed to resolve the problems of understaffing endemic in NHS maternity units, say MPs in a report from the House of Commons Health Committee. Safety of patients is being compromised by a lack of staff with over a third of NHS maternity units needing to improve on safety.

Although NHS maternity services have made large strides in improving safety, a lack of staff coupled with a culture of blame is preventing the NHS from improving still further. The report calls for a radical new approach to investigating and resolving incidents of harm to patients to enable the NHS to move away from a culture of blame.

Reacting to the report, Gill Walton, Chief Executive of the Royal College of Midwives, said that maternity staff have been "working incredibly hard, under extraordinary pressure for many, many years to deliver the safest and best possible care. They have been doing this within a system that often fails them by not giving them the staff, resources, and modern facilities they need to do their jobs as safely as possible….These reports show that the Government must step up and they must give our maternity services the staff and the money it needs, and they must do it quickly."

Professor Ted Baker, the Care Quality Commission's chief inspector of hospitals, told the committee that its inspections had found that 38% of NHS maternity services "require improvement for safety" more than in any other medical speciality.

Too few staff

At the heart of everything is a lack of staff. The Committee heard that although staff numbers had increased in some areas, there continue to be gaps in all maternity professions – midwives, obstetricians, and anaesthetists.

The figures for staff also do not take into account the high lev-

els of sickness and attrition present in a workforce that is overstretched and demoralised; even if a unit is fully staffed on paper, the reality is very different on the ground due to staff absences.

Health Education England has calculated that the NHS remains short of 1,932 midwives and a recent RCM survey indicated that 8 out of 10 midwives reported that they did not believe that there were enough staff on their shift to be able to provide a safe service. NHS Providers estimates that an extra 496 consultants are needed to work in Obstetrics and Gynaecology.

A recent example is Nottingham University Hospitals Trust's maternity unit, which is currently trying to fill 70 vacancies for midwives on its wards. Maternity services here are rated inadequate by the watchdog the Care Quality Commission (CQC) and have been understaffed for several years. An investigation by the Independent newspaper found managers at the trust were labelled a "Teflon team" who ignored pleas from staff about midwife shortages. The trust has seen dozens of babies die or been left with brain damage, according to The Independent.

The MPs on the committee were told of managers refusing to fund more midwives. Heads of Midwifery at maternity units can calculate how many midwives are needed using a well-established tool known as Birthrate Plus, however as Gill Adgie, Regional Head, Royal College of Midwives (RCM), told the committee:

"What we know from our Directors of Midwifery is that if a head of midwifery needs 30 more midwives in a service based on Birthrate Plus®, when she goes to the trust board with a business case, it is quite often knocked back."

Under-resourced training

A lack of staff means that training, which is crucial to maintaining patient safety and staff development, can not take place as often as it should. Often midwives can not be released to attend or to teach as there are no staff to cover for them. This is also the case with other specialties. As one trainee doctor told the committee:

"The problem with the staffing is that if it's so minimal then actually you can't release people. Study leave requests are often denied so how can we develop if we aren't given the tools to develop."

The MPs recommend that a proportion of maternity budgets should be ringfenced for training in every maternity unit and it must be sufficient to cover not only the provision of training, but the provision of staff to cover for those providing and attending training.

The NHS has seen major scandals in recent years that have left many babies with brain damage and many bereaved parents – Shropshire & Telford, Morecambe Bay, East Kent – and these have their origins in staffing and work culture issues. Investigations, such as those into Morecambe Bay maternity services and the Ockenden review into Shropshire & Telford maternity services, have found that the trusts involved have not learnt lessons,

"Although NHS maternity services have made large strides in improving safety, a lack of staff coupled with a culture of blame is preventing the NHS from improving still further"

continued to not investigate properly and failed to identify underlying issues in maternity care with evidence of blame instead being shifted to mothers. Parents seeking compensation, an apology and to make sure the same mistakes are not made again, often face many years of litigation as Trusts and individuals need to be found to 'take the blame'.

In 2019–20, NHS Resolution paid out £2.3 billion in compensation and associated costs for maternity claims, representing 40% of all claim payments. The NAO warned back in 2017 that this is likely to keep rising without fundamental change. A third of the bill is reported to go on lawyers' fees and the report noted that "if we were better at learning from and eliminating mistakes, this money could be spent on the provision of safe maternity care."

Reform needed

The MPs are calling for major reform of the compensation system for the NHS, with the UK adopting the system used in Sweden – a non-blame compensation scheme for injuries sustained as a result of medical treatment. Compensation is paid if care is not good enough, unlike the current system in the NHS where negligence has to be proved and cases can drag on for years.

The Swedish system leads to a culture of openness and a willingness to learn from what went wrong that led to a baby, its mother or both suffering serious injury or dying. In Sweden the number of avoidable birth injuries in its hospitals was halved after introducing this system.

The Ockenden report in 2020 triggered some new funding, with a £46.7 million funding package to provide 1000 more midwifery posts plus an additional £10.6 million has also been given to increase the obstetric consultant workforce by 80 FTE in 2021–22.

However, NHS Providers told the MPs on the committee that this funding is not sufficient to fund the 496 consultants required to reach the recommended 20% increase in obstetric consultants, which is £81 million per annum. NHS Providers also noted that maternity care needs a team – anaesthetists, maternity support workers, neonatal nurses – and to fully fund the broad team £200 – £350 million per year will be needed.

Sylvia Davidson

Summer crisis for depleted NHS hospitals

While many campaigners' eyes have been focused on the football, or the 'dead cat' of the Health and Care Bill, professional bodies have been trying to focus attention on the crisis of capacity has been racing out of control in England's hospitals.

The normally docile Royal College of Physicians chose the NHS 73rd birthday to publicise scary new survey findings showing more than a quarter of senior consultant physicians expect to retire within 3 years, many within 18 months – and pleading with government to pump extra resources into training new staff, giving the NHS "the best birthday present it could ask for – more capacity."

The RCP argues for three things tight-fisted Chancellor Rishi Sunak is unlikely to agree -- a doubling of medical school places, alongside increased spending on social care, and action to address health inequalities.

Meanwhile the Royal College of Emergency Medicine has focused on the extraordinarily high numbers of attendances at the more specialised Type 1 A&E units, and the even higher proportion of patients with conditions so serious they need immediate admission to a bed.

1,436,613 patients attended Type 1 Emergency Departments in June 2021, the highest ever figure since records began. More than a quarter of these 400,826 (27%) were admitted, and the total of all emergency admissions (535,000) was also the highest ever in June, when there has normally been less pressure on the NHS.

But with capacity still significantly reduced as a result of the Covid pandemic, the larger numbers led to more people facing delays, with only 73.2% treated or discharged within 4 hours – by far the lowest June percentage on record, with 1,289 patients delayed by 12-hours or more – almost double the figure of the previous month.

Canary in the system

Dr Katherine Henderson, President of the Royal College of Emergency Medicine, said: "We have a serious problem in urgent and emergency care. We are deeply concerned. We are facing record breaking figures in the high summer. We can only begin to imagine what this winter may bring.

"We ask that there is a transparent discussion about how the whole of the health service deals with the current levels of demand. Emergency care does not happen in a vacuum but is often the canary of the system."

The Independent has also flagged up long waits in A&E, with patients waiting up to 15 hours to be seen in Plymouth's Derriford Hospital, and up to eight hours at Leeds Teaching Hospitals Trust on Wednesday, where operations for some cancer patients

Acute Trusts with more than 200 fewer occupied beds
Q4 2018/19-Q4 2020-21

Trust	Reduction in occupied beds	Reduction as % of Q4 2018/19
Manchester University NHS Foundation Trust	519	25.7
Guy's and St Thomas' NHS Foundation Trust	384	26.7
London North West University Healthcare NHS Trust	376	30.5
United Lincolnshire Hospitals NHS Trust	329	28.0
Frimley Health NHS Foundation Trust	289	21.9
Sheffield Teaching Hospitals NHS Foundation Trust	281	19.9
Mid and South Essex NHS Foundation Trust	268	15.4
University Hospitals of Derby and Burton NHS Foundation Trust	253	17.5
University Hospitals of North Midlands NHS Trust	241	17.1
East Suffolk and North Essex NHS Foundation Trust	239	19.2
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	223	14.9
Royal Free London NHS Foundation Trust	218	21.5
York Teaching Hospital NHS Foundation Trust	216	22.8
Epsom and St Helier University Hospitals NHS Trust	209	26.4
South Tyneside and Sunderland NHS Foundation Trust	202	19.1
Gloucestershire Hospitals NHS Foundation Trust	200	21.3

were cancelled due to an increase in coronavirus patients.

The impact is also being felt by ambulance staff, where The Independent reports having seen data showing thousands of patients are being kept on hold for at least two minutes before 999 calls are answered, while new figures show record numbers of trips to A&E last month, and four ambulance trusts have issued "black alerts", with ambulances queuing outside hospitals to admit patients.

The pressure is not restricted to acute hospital services: NHS Providers' CEO Chris Hopson points out the increase in people in contact with mental health services – up 9% to 1.42m in April compared with 2020, with a 14% increase in front line care contacts, and a massive 54% increase since last year in out of area placements of mental health patients for whom there is no local bed.

The pressure has meant that even though trusts managed to reduce waits over 18 weeks by 80,000 and waits of more than a year by 50,000, the waiting list as a whole grew again – to 5.3 million.

Meanwhile the Royal College of Emergency Medicine has returned to a familiar campaign – demanding a restoration of the numbers of front line beds. An explanatory paper notes the continued decline in bed numbers since 2010, that was worsened by measures to address the Covid pandemic, and reminds us that the coming winter and future peaks of demand will require the lost bed to be brought back into use.

The RCEM calculates that over several year the average number of admissions per bed has been 11.7, and from this estimates that depending upon the scale of the winter pressures the NHS needs to reopen between 5,000 and 16,000 beds.

Of course the extra beds would also raise the need for extra staff – which the RCEM and other professional bodies have been demanding for several years.

Meanwhile Lowdown has been looking more closely at the uneven level of bed reductions across hospital trusts in England, comparing the most recent figures for occupied beds (Quarter 4 2020-21) with the equivalent pre-Covid figures (Q4 2018-19).

We calculate that the England average reduction of occupied beds in that time across all trusts is 14.1% – but 79 trusts have lost a higher percentage, and the percentage loss of occupied beds varies sharply. Among the acute trusts the reduction varies between just 1.2% (Warrington and Halton Teaching Hospitals and Portsmouth Hospitals) and 30.5% (London North West University Healthcare). Nineteen more acute trusts have lost one in five (20%) or more of their occupied beds.

On numbers of occupied beds lost, the England total is 14,562 since the equivalent period in 2019, but at trust level Manchester University FT tops the list having lost 591, followed by Guy's & St Thomas' FT (now merged with the Royal Brompton) with 384, London North West (376) and United Lincolnshire Hospitals (329), while eleven more acute trusts have lost the use of between 200 and 289 beds since 2019 (see table).

Looming dependency on private sector

Last year NHS England began a debate on the costs of reorganising and refurbishing hospital buildings to restore the lost capacity – but this debate has ground to a halt for lack of capital even for basic maintenance, where the backlog bill is now in excess of £9 billion.

So while the NHS is unable to use all its own beds to treat waiting list, emergency and Covid patients the private sector is delightedly stepping in to provide capacity to treat NHS funded elective patients under a massive £10bn 4-year "framework agreement."

It should be clear to all that without a major government U-turn, to implement a programme of capital investment to reopen NHS capacity, at the end of this 4-year period the NHS will have become institutionally dependent upon private sector beds to maintain its elective caseload – and the biggest-ever privatisation of clinical services will have been carried through without any systematic protest.

This also makes a nonsense of any talk of "integrated care": billions will be flowing out of meagre NHS budgets into the coffers of private hospital corporations, leaving front line services starved of resources, while scarce NHS nursing and medical staff will have to be split up with teams having to work away from the main hospital sites in small private hospitals – making them unavailable to assist teams coping with emergencies and complex operations.

The under-funding of the core NHS services is emerging as the most cynical and effective means to drive increased privatisation – well before the Health and Care Bill is debated or makes any impact.

John Lister

New Health & Care Bill will gag local voices

A major loss of local accountability and control, coupled with a massive expansion of centralised powers, and the danger of a new wave of lucrative NHS contracts to be awarded without competition are among the main features of the government's controversial Health and Care Bill to drive another major top-down reorganisation of the NHS.

Fewer local bodies, less local voice

The Bill would abolish local Clinical Commissioning Groups, 207 of which were established back in 2012-13, with 106 still functioning in April 2021, and reduce "local" control over the NHS in England to just 42 "Integrated Care Systems" (ICSs), some of which would cover very wide areas, and populations of up to 3.2 million.

In preparation for this, CCGs in many parts of the country have already been systematically merged into bigger, less accountable and more unwieldy bodies, leaving only the hollow pretence of local voice for local communities and council scrutiny committees, while decisions are taken by new, remote bodies with little or no concern for local health needs and inequalities.

ICSs would consolidate these mergers, leaving the NHS with less local accountability and fewer "local" bodies deciding policy than any time in the last 50 years.

To make matters worse the new ICSs would each be tied to a tightly limited single pot of allocated funding after a decade of austerity and falling real terms funding – and at a time when NHS England has already begun cracking the whip for tighter financial controls, and therefore looking for cuts to balance the books.

In this context it is alarming to see that Paragraph 78 would re-

voke the section in the Care Act 2014 which requires local authorities to carry out social care needs assessments before a patient is discharged from hospital.

Although it does not change existing legal obligations on NHS bodies to meet health needs, it opens the door to uncoordinated discharge of patients into under-funded and under-provided social care. In any ICS where local government and community health resources and services are lacking, this "discharge to assess" model could result in patients being dumped out of hospitals with inadequate support.

ICS boards

Health Secretary Sajid Javid would have a veto over the appointment by NHS England (and over any attempted subsequent removal) of all 42 ICS Board chairs, who then get the final say on the appointment of other board members.

On recent form, a rampant expansion of cronyism into the new bodies seems inevitable.

Nor is there any explicit requirement that the Boards must meet in public or publish their board papers, although NHS England has stated their preference for this: nor is there any commitment, given the wide geographical spread of some ICSs, for meetings to be made accessible online.

And while local authorities have been weakened by a decade of brutal cuts in spending, and get just one seat on each ICS, the private sector could be given a stronger voice. A vague phrase in the Explanatory Notes on the Bill adds that beyond the minimum five Board members "local areas will have the flexibility to determine any further representation."

In one of the early ICS shadow boards (Bath, Swindon and Wiltshire) a Board seat with voice has been given to Virgin, raising the question of how many additional private companies and management consultants might be invited to join the decision making at Board level.

The GP representation on the Board could, under the Bill's formulation also potentially be a GP working for Centene, Virgin, or another corporate provider that has bought up GP practices.

Powers on reconfiguration

On hospital reconfigurations – a lingering concern in many parts of the country, the Bill would give new powers to the Secretary of State to intervene directly at any stage, either to block local plans or indeed to demand ("be the catalyst for") a reconfiguration – possibly closing, merging or downsizing local hospitals and services.

The Explanatory Notes state that the current powers of local authorities to refer plans that they find controversial to the Secretary of State would be "amended" (rather than scrapped as February's White Paper proposed), and the Independent Reconfiguration Panel which is supposed to examine the case for contested local changes (and was also set to be abolished) will also remain in place.

However the main player would be the Health Secretary, and so the extent to which there remains any local control is left to his discretion.

138 new powers

These local interventions are only one aspect of a wide-ranging extension of power and control in the hands of the Health Secretary. According to The Independent's health specialist Shaun Lintern, the Bill would create 138 new powers – including seven allowing the Secretary of State to effectively rewrite the law in future through secondary legislation.

This comes less than ten years after Andrew Lansley's 2012 Health and Social Care Act, which was forced through by David Cameron's government with the backing of the Liberal Democrats.

That Act entrenched a regime of competitive tendering, resulting in a sharp increase in privatisation of community health and other clinical contracts, while it also encouraged Foundation Trusts to massively increase their treatment of private patients.

But as NHS England has attempted to make the system work, key parts of the 2012 Act have simply been ignored: the new Bill for example includes (Clause 39) repeal of the requirement in the Act for all NHS Trusts to become Foundation Trusts, and notes "NHS Trusts still exist, and this section has never been commenced."

Scrapping Section 75 – but no end to privatisation

The Bill now proposes to go further and repeal the hated Section 75 of the 2012 Act, and the accompanying regulations which require Clinical Commissioning Groups to put services out to tender. However there is plenty of scope for further privatisation in the new Bill.

David Hare, chief executive of the private sector's lobby group the Independent Healthcare Providers Network, has pointed out that despite the attempts in the 2012 Act to make it compulsory, "the reality is that competitive tendering has always been a minority sport in the NHS, with just 2% of NHS contracts by value let by competitive tender in recent years…."

Private sector analyst William Laing back in February conceded the White Paper could mean that contracting out of community health services might "grind to a halt," affecting firms like Virgin Care, Serco and Mitie: but he argued it was unlikely to have much impact on the big money contracts – mental health, elective care and diagnostic services, where the NHS lacks sufficient in-house capacity.

So axing tendering does not end much privatisation, if any. And

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Sajid Javid, the austerity-mad former Chancellor described by the Times as "a Thatcherite small-state Conservative" seems likely to be an even bigger fan of privatisation than Matt "no privatisation on my watch" Hancock.

Regulation of contracts

Scrapping Section 75 also raises the question of what new system will apply to regulate the awarding of contracts. There is no clear mechanism or commitment to prevent more of the scandalous behaviour that became normalised during the pandemic – awarding contracts worth tens of millions to Tory donors and cronies without competition.

On recent form, who would trust the government to uphold standards? Or indeed NHS England, which has spent the last seven years developing workarounds to avoid competition while still widening privatisation. Most contracting out now takes place through much larger "framework contracts," which list approved providers from whom commissioners or trusts can choose to award contracts without any competitive process.

The most conspicuous of these is the 4-year £10 billion framework contract through which a long list of private hospitals and clinics make themselves available to treat NHS-funded patients from the waiting list that has been swollen by a decade of austerity topped off by the capacity cuts following the Covid pandemic.

National Health Executive magazine explains that there is to be "a new procurement process, removing the competitive tendering element: "The nature of what this entails has not yet been discussed, but would involve the end of CCGs."

Regulation of professions

The Secretary of State's new powers in the Bill also include the ability to abolish an individual health and care professional regulatory body or remove a profession from regulation "where regulation is no longer required for the protection of the public."

The suggestion in the White Paper that such changes to professional regulation might be made in pursuit of "financial and efficiency savings" by reducing the number of regulators is an alarming indicator of the skewed priorities of the government.

And the suggestion that some professions could be removed from regulation is bound to stoke fears about deregulation, and that trusts may be driven to replace professional staff with less qualified and lower-paid staff, with consequent undermining the quality of health care.

Transition from CCGs to ICSs

It is inevitable that in the process of merging and abolishing CCGs, replacing them with far fewer commissioning bodies, there will be months or years of dislocation and uncertainty for CCG staff, a widespread loss and reorganisation of jobs, costing many millions in redundancy payments, and a long-running scramble to secure the remaining posts.

"The suggestion that some professions could be removed from regulation is bound to stoke fears about deregulation, and that trusts may be driven to replace professional staff with less qualified and lower-paid staff, with consequent undermining the quality of health care"

There are dangers in this process that equality issues are sidelined and that the resultant new system takes a prolonged period to establish itself. Huge amounts of valuable time, energy, resources of senior management and staff in both commissioning and provider bodies will be diverted from the pressing concerns of the growing crisis in A&E, the huge backlog of elective cases waiting for treatment and the development of a credible workforce strategy for the NHS and social care.

The NHS Confederation's spokesperson on ICSs Dame Gill Morgan has warned that the proposals could bog down NHS bosses in interminable meetings, creating a "bureaucratic nightmare."

The continued under-funding of both NHS and social care also preclude any possibility of significant improvement in services from this reorganisation, which takes place in a period of renewed austerity and is not backed by additional resources in terms of staff or funding.

Nothing in the Bill provides any convincing evidence that it will yield any positive results, let alone any sufficient to make the costs of this major upheaval worthwhile.

Fighting the Bill

The fight to stop the Bill opening up the NHS to crony contracts and crushing any local voice or accountability has to begin with rejecting its Second Reading on July 14: but it must also look to win broad support for amendments that limit the damage that can be done.

John Lister

The Lowdown will put forward a longer list of key topics and suggestions for amendments in a follow-up article online. Keep up to date with the campaigning and analysis of the Bill at https://lowdownnhs.info

£10bn NHS community diagnostics contracts attract firms

Firms are being invited to bid to run 150 new community diagnostic facilities as part of £10bn NHS framework contract which has been advertised by NHS England.

Planning for these new facilities had been underway since before the pandemic, as part of a review conducted by Professor Mike Richards, but reports suggest that the scheme has been increased in size to help cope with the scale of diagnostic working that the NHS is now facing.

The review said community diagnostics hubs should be separate from acute settings, releasing pressure on hospitals and should provide a wide range of services including:

- Imaging capacity: including CT, MRI, ultrasound, plain X-ray;
- Cardiorespiratory capacity: including echocardiography, ECG and rhythm monitoring, spirometry and some lung function tests, support for sleep studies, blood pressure monitoring, oximetry, blood gas analysis;
- Pathology services: including phlebotomy;

- Endoscopy facilities; and
- Consulting and reporting rooms.

The offer to involve private providers was welcomed by the Healthcare Providers Network chief executive David Hare who told the HSJ "a mixed economy" of independent and NHS providers would likely be used for the new community hubs.

"The five-year timeframe should support private sector investment to deliver new services and add much-needed NHS diagnostic capacity," he added.

This latest move will likely see a significant increase in commercial involvement, but as yet it is unclear how the new units will be built and staffed.

In May, NHS England gave NHS trusts seven options for setting up a diagnostics network, one of which is "outsourcing" of the entire network to a commercial partner, which is marked in its guidance as one of the only two "highly feasible" options, alongside "collaboration" between two or more NHS trusts. Therefore the overall situation across England is likely to be a mix of public and private, but this latest diagnostics contract is a further deepening of private sector involvement

Under capacity

NHS diagnostic services have been in need of reform and investment for many years and there has been an increasing reliance on expensive outsourcing, because of a lack of NHS capacity.

Demand is soaring, has been soaring in recent years. 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 regularly breached.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.

Increasing diagnostics capacity is an integral part of the NHS long term plan and key to improving the detection of disease at an early stage which has been the one of the key reasons that survival rates in the NHS are lower for some cancers than in other parts of Europe.

Paul Evans

See https://lowdownnhs.info for a longer version of this article

Silly season bid to sneak through new prescription charges

Ministers have marked the 73rd anniversary of their party voting against establishing the NHS to launch a surreptitious consultation on the imposition of prescription charges on people aged 60 to 66, to raise an estimated £226m per year..

The 8-week consultation was launched on July 1, just before the NHS birthday, to run through the summer holiday months when Parliament is in recess and the news media are stuffed with trivia, hidden away behind the hysteria over the football, and while many campaigners have been fixated on the recent White Paper and Health and Care Bill.

It argues that the upper age limit for prescription charges was initially linked with the pension age for women. Now, having repeatedly pushed this age further upwards to deny people pensions until 66 and soon 67, they want to follow up by saddling those who have already lost out with prescription charges – which have just risen again to £9.35 per item.

England stands alone

Two options for change would either impose the charges in one go on all aged over 60, or (the preferred lower profile method) phase them in. Neither option is acceptable.

England is the only country in Britain that is still subjected to prescription charges, which

have been abolished by devolved governments in Wales (2007) Northern Ireland (2010) and Scotland (2011).

In each case the limited extra cost of scrapping charges on the 10% of NHS prescriptions that were not covered by exemptions has been seen as good value in exchange for ensuring that no patient is prevented from accessing all the medication they need by cost barriers.

This indeed was the principle underpinning the provision of medical, dental and ophthalmic services free of charge when the NHS was set up in the war-torn economy of Britain back in 1948.

Experience disproved Tory claims that this would simply create a "moral hazard" in which freely available drugs, spectacles and fillings would be dispensed and consumed "frivolously" at an ever-increasing rate.

However there is clear evidence that imposition or increases in charges deter the poorest people from accessing medication or preventive treatment (while of course the poorest are also the most likely to have complex medical needs and chronic ill-health).

Ministerial contempt

After the Johnson government's ideological precursors in the Thatcher government had controversially hiked up prescription charges three-fold from 1979-1984, an IFS report found that the result was a 40% reduction in the number of chargeable prescriptions dispensed.

When the Tories went on to impose charges for eye tests, the rate of testing plummeted from 25 per 1,000 people to just 8.

Now, even though prescription charges raise a vanishingly small proportion (less than £5 in every £1000, 0.4%) of the £137 billion annual cost of the NHS in England, and the financial plight of many of the poorest families has been worsened and health inequalities widened by the Covid pandemic, ministers have decided to demonstrate their contempt for evidence and the values of the NHS.

The cynical 'Impact Assessment' published as a justification for the new charges fails to mention the positive impact of scrapping charges, and shies away from evidence around the world of the deterrent impact of charges on those with lowest income seeking health care.

"The consultation was launched on July 1, to run through the summer holiday months when Parliament is in recess and the news media are stuffed with trivia, hidden away behind the hysteria over the football, and while many campaigners have been fixated on the recent White Paper and Health and Care Bill"

It deals only in percentages, not numbers, and notes that 61% of the current 60-66 age group (equating to 1.5m people) are 'high users' of prescription drugs, averaging 34 items per year, compared with just 28% of 55-59 year-olds. 27% of high users in other age groups do not, for whatever reason, buy prepayment certificates (costing £108 per year or £120 if paid quarterly or monthly): but the Assessment does not look at the numbers of people aged 60+ who might struggle to find upfront payments or pay singly for prescriptions.

Negative impacts on health

It admits that among asthma patients 57% of whom reduced medication or had skipped medication as a result of prescription costs, resulting in 24% of those surveyed suffering asthma attacks, more than half of them serious enough to require hospital treatment. But it does not explore the consequent costs to the NHS and consequences for the patients and their families.

The £226m they are seeking to screw from just 2.4m people in this age group would increase the total prescription charge income by more than a third, but it's still a drop in the bucket.

It would bring total prescription charges up to just £840m – out of a current NHS drugs bill of £10.5bn. After Rishi Sunak's recent budget, which denied the NHS any extra funding to recover after Covid, the Assessment's claim that this small amount of extra money would be "invested" in the NHS – and yield an astounding £8.4bn worth of improved health, despite brutal cuts in public health spending – defies belief.

Tax the rich, not the poor

If ministers want extra money for the NHS they should start to tax the billionaires and corporations who have coined in profits while millions have struggled during the pandemic.

Rather than slapping on new charges that will undermine the NHS and its principles they should be scrapping the charges on the 10% of prescriptions that are paid for.

That's what pensioners' groups, trade unions, opposition parties and campaigners need to be saying loud and clear in the next few weeks.

John Lister

Ramsay bids to become largest UK private health supplier

The Australian private hospital chain Ramsay has increased its offer to buy the UK company Spire Healthcare.

The takeover will mean Ramsay will merge Spire's 47 hospitals with Ramsay's 40 UK facilities, and become the UK's leading private hospital group.

Ramsay joins other private providers who aim to benefit from a surge in their business due to long NHS waiting lists.

If the merger goes ahead Ramsay will overtake the recently merged Circle/BMI group, which had become the UK's largest.

The new offer of 250p per share values the company at about £1.4 bn; the previous offer in May this year was 240p per share valuing the company at about £1 bn. Spire's board has recommended that this offer be accepted.

Only one bidder

Investors in Spire, including Fidelity International and Toscafund Asset Management, objected to the first offer in May saying it did not value the company high enough. Toscafund, which owns about 5% of Spire, has also rejected this latest higher offer once again saying it does not value the company high enough. Toscafund and other investors believe that Spire is well placed to benefit from removal of covid restrictions, which they expect will lead to a wave of demand for elective surgery.

The deal must be approved by 75% of voting shareholders for it to go ahead. The Spire board has said there have been no other approaches.

Pre-pandemic, Ramsay has been heavily dependent on income from NHS contracts, at around 80% of its annual income in the UK, whereas Spire had derived around 30% of its income from the NHS. Outside of the UK Ramsay operates in 11 countries, but its primary base is its home market of Australia, where it is the largest operator and has over 200 facilities.

The UK private healthcare sector took a major hit in 2020 as the Covid-19 pandemic began but it was saved by the UK government which paid to take over the vast majority of its facilities for use by the NHS, in exchange for paying all the companies' costs, including debt and interest.

Now investors and commentators think private healthcare is expected to benefit from increased demand due to the ever-increasing NHS waiting lists. High levels of income are expected from contracts with the NHS and from people paying directly.

Over 90 private operators, including Spire Healthcare, have signed up to a 4 year deal with NHS England that began in March 2021 worth in total around £10 bn. Unlike the previous deal, the new deal will pay them based on work carried out.

Sylvia Davidson

Campaigners highlight covid threat to prisons in India

Doctors in Unite - the doctors branch of the Unite the union, have issued a statement to highlight the plight of political prisoners in Indian prisons who are subject to worsening conditions brought on by rapid spread of Covid-19..

They also raise the “overcrowded and unhygienic” conditions which leave an estimated half a million indian prisoners exposed to a high level of the virus.

Dr Jackie Applebee, Chair of Doctors in Unite. Said: “Among those locked up are a considerable number of people whose only ‘crime’ has been to dissent or to take part in non-violent protests. Some of them are elderly, many are in poor health and particularly vulnerable to catching the virus, others have already been infected and reportedly either being denied treatment or only receive it after enormous pressure from their friends and families.”

Among those mentioned in the medic’s statement is Prof Anand Teltumbde, a prominent academic an outspoken critic of the Indian government who was arrested in April, along with 10 lawyers, poets and activists, accused of instigating caste violence at a Dalit rally in Bhima Koregaon village in the western state of Maharashtra in 2018.

Inmates are terrified

Their confinement has been criticised by campaigners and human rights organisations who have been pressing for their release. Meenakshi Ganguly, South Asia director for Human Rights Watch, a US based non profit commented: “Indian authorities are using draconian counterterrorism laws against activists simply for criticizing the government or raising their voices against injustice.”

An investigation by The Independent looked at the situation inside the prisons. Many of the inmates were to scared to speak for fear of reprisals, but criminal lawyer Nipun Arora told the Independent: “A lot of inmates have been terrified of the possibility that they might get infected inside and this fear was present during the first wave as well. The fear is stemming primarily from the fact that neither is social distancing being practised, nor are masks being used properly by the inmates. The conditions of the prisons are even otherwise considered unhygienic.”

Studies have shown that the detention facilities create unique populations that are often more susceptible to the spread of disease. The World Health Organisation (WHO), drew the attention of world leaders to the “heightened vulnerability of prisoners and urged them to take all appropriate public health measures in respect of this vulnerable population”.

According to the non-profit Commonwealth Human Rights Initiative (CHRI) says there have been more than 22,000 reported cases amongst inmates, but these figures are several months out of date.

The government made attempts to relieve the situation by the mass release of 60,000 inmates back in March 2020, but prison numbers have risen again because of the pace at which the police have made new arrests.

The Indian Express provides an update from May: “Before decongestion measures can be evaluated, accurate data is needed on the prevalence of infection in jails. But no official data is available. There are worrying reports of inmates being denied COVID tests for days despite exhibiting symptoms.”

The health threat is not helped by a history of overcrowding - the average occupancy rate across Indian jails in 2019 was 118.5 per cent – highest inl Delhi topping the chart at 174.9 per cent according to National Crime Records Bureau’s 2020 report.

deal, the new deal will pay them based on work carried out.

Paul Evans

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modest rises in patients being admitted to hospital will undermine our ability to treat the record 5m patients waiting for treatment. Why is the prime minister knowingly putting more people at risk of becoming ill when masks are proven to be effective and can reduce the spread of infection?"

Health union Unite said the lifting of restrictions represented a 'gung-ho' approach and called for a review of the decision to end social distancing and mask wearing in hospitals, clinics and other NHS buildings.

WHO head of emergencies Mike Ryan even suggested the government's approach risked coming across as "epidemiological stupidity". And one NHS consultant radiologist, along with a senior clinical lecturer and more than 100 international scientists and doctors writing a joint letter in the Lancet, all described Downing Street's plans as "a dangerous experiment".

Even the Daily Mail felt obliged last week to note that more than 100 patients could die from covid each day following the 'freedom day' relaxations on 19 July, after health secretary Sajid Javid admitted daily cases of infections were now close to 50,000 and could soon reach 100,000.

Quite why the government is so determined to keep to the 19 July date is unclear, but the Evening Standard offered one explanation. It claimed last week that officials at the Department of Health & Social Care subscribed to a hybrid version of the much-discredited concept of herd immunity, and were expecting the virus will "run out of people to infect" within weeks now that so many have been vaccinated.

Similar hints of libertarian bravado were on display in health secretary Javid's Sunday Telegraph interview, when he suggested that lifting most of the covid restrictions – and paying more to private health providers – would actually help solve the waiting list crisis.

Public pushback

But public opinion generally seems to be pushing back against the easing of restrictions, with polling suggesting 90 per cent of people were against the policy, and 70 per cent suggesting mask-wearing and social distancing should continue for at least another month.

And a look at what's happening in the Netherlands right now should also give the government pause for thought.

Lockdown measures – curbs on nightclubs, music festivals and restaurants – which were lifted on 26 June as cases fell, have already been re-imposed there after a surge in covid infections. Nearly 7,000 new cases were reported over 24 hours one day last week, compared to less than 1,000 a day a week earlier. Within days there were 10,345 new daily cases, the highest figure since Christmas, representing a daily average 7.5 times higher than 11 days previously.

Moving to step four therefore seems like a reckless experiment with both the public's health and that of the NHS. Surely it would make more sense to stick with 'Stay Home. Protect the NHS. Save Lives' for a little bit longer, eh Mr Johnson?

Martin Shelley

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