HEALTH CAMPAIGNS TOGETHER #our NHS

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NHS is struggling to cope and desperate for staff: the last thing it needs is a massive top down reorganisation

The wrong Bill at the wrong time – BMA

John Lister

All but 3 Tory MPs have obediently nodded through the second reading of the Health and Care Bill, most of them clearly having not read it.

Labour MPs and Shadow Health Secrtary Jon Ashworth spoke and voted against the Bill both because of its timing but also its content, which does potentially open doors for greater private sector involvement and control.

The BMA Council has also now voted to oppose it on similar grounds.

However some Tories who have paid more attention are also reportedly uneasy about the sweeping new top-down powers it will give to Health Secretary Sajid Javid and about the boundaries of the 42 "Integrated Care Systems" (ICSs) that are given legal status.

Delay

Others, possibly even Javid himself, who wanted to delay the Bill but was told to push ahead by PM Johnson, may well be wondering why this legislation, which will disrupt the NHS in England for the next 2 years, has to be pushed through ***now*** – in the midst of a pandemic and a mounting crisis throughout the NHS.

The Bill has nothing useful to say about the workforce crisis, nothing at all to say about social care, and brings no extra revenue or capital to help trusts reopen closed beds and get capacity back to pre-covid levels: it will not recruit a single nurse or bring the treatment of one extra patient – or bring any genuine integration of NHS and cash-strapped, privatised social care.

Diversion

Instead it will divert management time, effort and attention away from the pressing tasks of the day into yet another top-down reorganisation – and make the service even less accountable to local communities.

Two thirds (29) of the 42 ICSs have already been given the go-ahead, some even claiming to already be delivering improvements, although none have clearly stated what, with unchanged spending limits, they can achieve as ICSs that they can not do now.

Worse, the Bill itself with its 138 new powers for the Secretary of State, its vague phrasing and repeated reference to "flexibility", its omissions of commitments from previous legislation, and dependence on still unpublished guidelines and regulations, leaves scope for potential reductions in services.

It also creates scope for the private sector, which ministers have consistently favoured during the pandemic, to step in to positions of influence on at least some ICS boards and committees.

The much-vaunted repeal of Section 75 of the 2012 Act, which requires local CCGs to put services out to competitive tender, will stop little, if any contracting out: only 2% of clinical contracts are subject to competitive tender.

The change also applies only to clinical services – and is not linked to any proposal to bring privatised services back in-house, or make the NHS the default provider.

King's Fund boss Richard Murray, poo-pooing concerns over ongoing privatisation, gives the game away when he admits the Bill would make it easier for services to remain

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INSIDE THIS ISSUE

Record summer crisis for depleted NHS hospitals – and staff

Articles on these pages first appeared in The Lowdown July 12

John Lister

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 Independent has 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 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.

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.

Record June levels of demand for emergency care in summer crisis

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.

Pandemic impact

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.

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 same pressures have also predictably continued to add to numbers on waiting lists.

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.

Wrong Bill, wrong time …

from front page

with "existing providers ***like the NHS***" – i.e. NHS or current private contractor.

The new rules for procurement remain unexplained – and after more than a year of brazen crony contracting for Test and Trace and PPE contracts without competition, critics can be excused for suspecting that the Bill could leave the NHS open to more of the same.

It will also axe any genuinely local control over services.

The 42 ICS areas, with populations up to 3.2 million, are much bigger in scope than the CCGs they replace, and their chairs will be appointed top-down by NHS England and signed off by the Secretary of State – whose agreement would be needed to remove them.

The chairs in turn get to appoint other members of the ICS Boards, with no maximum size, and no bar on private companies taking seats – as Virgin already has in the shadow ICS in Bath, Swindon and Wiltshire.

Sneering

Of course it's possible to exaggerate the extent to which this Bill in itself amounts to or leads to privatisation, and some extreme assessments provide a handy targets for sneering by think tanks that always assume government policies will work out for the best, and journalists who look only at the repeal of Section 75.

But the overwhelming vote by the BMA Council to oppose the Bill on the day of its second reading is welcome and significant, and lends weight to Labour's decision to oppose it.

A BMA press release explains:

"It is the wrong time to be reorganising the NHS, fails to address chronic workforce shortages or to protect the NHS from further outsourcing and encroachment of large corporate companies in healthcare, and [the Bill] significantly dilutes public accountability.

"The BMA is also concerned about the wide-ranging excessive powers the Bill would confer on the Health Secretary."

Of course there will be those who prefer to take it on trust that the government that has handed out billions in Covid contracts to inept and incompetent PPE suppliers and Test and Trace contractors headed by cronies and donors really wants to limit privatisation and integrate services. They will find a warm reception in the news media.

There will be others who will insist that we must only focus on trying to "kill the bill," despite the hefty Tory majority and the fact that the SNP, which opposes the Bill, will not vote on an English policy matter. They will couch their arguments in ever more desperate and hysterical terms that will make it impossible to draw in any broad support.

For the rest of us the next step must be identifying the key issues on which it will be possible to unite the opposition parties and seek to split off Tory back benchers in support of amendments which limit the damage that can be done by a Bill that offers dangers rather benefits for the future of the NHS.

Hobbled NHS and £10bn deal for private hospitals make a nonsense of "integration"

An explanatory paper from the Royal College of Emergency Medicine 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.

Reopen beds

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 of the currently unused 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).

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

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). Eleven more acute trusts have lost the use of between 200 and 289 beds since 2019 (see table).

Lack of capital

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.

The backlog bill for maintenance 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."

Biggest privatisation

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.

Meanwhile 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.

Maternity safety compromised in a third of NHS trusts

Sylvia Davidson (from a much longer article in The Lowdown)

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.

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."

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.

Although NHS maternity services have made large strides in improving safety, 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.

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.

Nottingham University Hospitals Trust's maternity unit, where maternity services here are rated inadequate by the watchdog the Care Quality Commission (CQC), is currently trying to fill 70 vacancies for midwives on its wards..

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 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, continued to not investigate properly and failed to identify underlying issues in maternity care with evidence of blame instead being shifted to mothers.

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

Social care assessment backlog revealed

As the Health and Care Bill plans to authorise NHS hospitals to "discharge to assess" older patients, the Association of Directors of Adult Social Services (ADASS) have published their latest spring survey of almost all of the 152 social services councils in England – to reveal a backlog of 75,000 disabled and older people waiting for help with their care and support.

Almost 7,000 have been waiting more than six months for assessment, while more than 19,000 who have been assessed and deemed eligible are waiting for a service or direct payment to arrange their own care and support.

£600m cuts

But far from being able to allocate the necessary extra resources to clear this backlog, councils are being forced to plan for savings of £600m in social services spending this year.

This follows cumulative cutbacks of more than £8 billion since the austerity regime first kicked in under George Osborne in 2010. And Rishi Sunak's budget made clear there is no end in sight to austerity for health or social care.

Norfolk, for example is proposing to make more than half of its £40m savings required next year by slashing spending on adult social services by £17.7m from and children's services by £8.7m.

Staffing crisis

Social care employers also face a huge recruitment and retention crisis in the low-paid, under-valued care workforce, with more than 100,000 vacancies and the previous channel of recruitment from EU countries cut off by Brexit and Priti Patel's brutal immigration controls.

While council leaders and social care chiefs continue to plead for government to deliver the long-promised plans to reform social care, ministers seem more interested in pushing through new laws that will increase the pressure on already crisis-ridden services.

Listing key dangers in Health & Care Bill

John Lister

A major loss of local accountability and control, coupled with an 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.

It aims to consolidate and give legal status to the changes that have been carried through by NHS England since 2014 outside of the legal framework of the 2012 Health and Social Care Act.

Scrapping Section 75 – but no end to privatisation

The Bill proposes to 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, too.

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…."

In place of conventional tendering, most contracting 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.

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. The measure falls well short of the call from unions for the NHS to become the 'default provider' of services, with outsourced contracts being brought in-house as they expire or collapse.

Regulation of contracts

Scrapping Section 75 also raises the question of what new system will apply to regulate the awarding of contracts. On this issue the Bill is a pig in a poke: there is no clear mechanism or commitment to prevent more of the scandalous behaviour that was normalised during the pandemic – awarding contracts worth tens of millions to Tory donors and cronies.

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 widening privatisation.

In place of conventional tendering, most contracting 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. It comes after discussions with NHS England, the Local Government Association and the health and care sector, to refine the blueprint."

Fewer local bodies,even less local voice

The Bill would abolish the Clinical Commissioning Groups, 207 of which were established by the 2012 Act, 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 over 3 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

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Johnson forced Javid to push the Bill forward, Rishi Sunak's rigid grip on finance prevents NHS restoring capacity

Dangers in the Bill

– from page 5

only the hollow pretence of local voice for 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 institutionalise 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 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.

The Bill – most of which was drafted to the instructions of Matt Hancock – would give far-reaching new powers to his successor Sajid Javid, which he has admitted to being uncertain about.

It gives Javid a veto over the appointment by NHS England (and over any attempted subsequent removal) of all 42 ICS Board chairs, who then get to decide on the appointment of other board members.

It also gives him powers to direct NHS England, and requires him to be informed of any change, even temporary, in local service provision anywhere in England.

Each area would also have to establish a largely toothless "Integrated Care Partnership,"

(ICP) led by local government, and "tasked with developing a strategy to address the health, social care and public health needs of its system," to which the ICB and local authorities will have to "have regard" when making decisions.

Charter for cronyism

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

With no public members or trade union members to counter-balance the political appointments, and no clear mechanism established for their selection, the private sector may well not even feel the need to bother to get direct representation.

Key sections of the Bill are left vague, awaiting the publication of further "guidance," not least a set of criteria for appointments to the Integrated Care Boards, which is yet to be developed by the Department of Health and Social Care and NHS England, and statutory guidance outlining more precisely the roles and responsibilities of the integrated Care Boards and the ICPs.

Nor is there any commitment, given the wide geographical spread of some ICSs, for meetings to be made accessible online, while the ICPs are not even required by the Bill to meet in public or publish their Board papers.

The subordinate role of local government is illustrated by the fact that no matter how big the area covered by the ICS, they are to get only one guaranteed seat on the board, and that is likely to be an officer rather than an elected councillor.

But while local authorities have been weakened by a decade of brutal cuts in spending, the private sector could gain a stronger voice. The Bill's formulation on representation from general practice could potentially be a GP working for Centene, Virgin or another corporate provider that has bought up GP practices.

And 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 more private companies and management consultants might be invited to join the decision making at Board level.

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 will also remain in place.

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

Discharge to assess

And despite the title of the White paper and much of the rhetoric of the Bill talking of "integration," there are no proposals for integration with, or addressing the problems of social care. Subjecting over-stretched and under-funded services to CQC inspections seems likely only to expose further the desperate situation in these largely privatised services (see page 4).

Nonetheless one clause removing the legal requirement for social services to assess the needs of vulnerable patients before they can be discharged from hospital seems certain in many areas to lead

Michael Kemp/Alamy

The last time around: Veteran campaigner, the late, great June Hautot, giving Andrew Lansley some advice on what to do with his Health & Social Care Bill

to patients being unceremoniously "dumped" out of NHS hospital beds without the community health, primary care and social care support they need.

This is likely to pile fresh burdens on families and carers as well as the patients themselves, who will be in the weakest possible position to secure any additional support.

138 new powers

These local interventions are only one aspect of a wide-ranging extension of power and control in the hands of Sajid Javid. According to Independent health specialist Shaun Lintern, the Bill would create 138 new powers – including seven allowing the Secretary of State of 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 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.

The fragmentation of services which followed has made the NHS more chaotic and wasteful, while many private contracts and contractors have also folded long before completion, leaving the NHS to pick up the pieces.

As NHS England has attempted to make the fractured system work,

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 will also remain in place.

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

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

"As not all NHS Trusts converted to NHS Foundation Trusts, NHS Trusts still exist, and this section has never been commenced."

Regulation of professions

The Secretary of State's new powers in the Bill 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, replacing professional staff with less qualified and lower-paid staff, and consequent undermining the quality of health care.

Transition from CCGs to ICSs

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

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, telling the HSJ:

"… particularly if you're in a big ICS, that could be an absolute panoply of meetings and subcommittees, all of which are valuable in governance terms but in delivering the vision of partners … to deliver long term health [solutions] it could be a bureaucratic nightmare."

The continued under-funding of both NHS and social care also limit 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.

This article has been updated and modified from this article in The Lowdown

No lost golden age!

A brief history of NHS reorganisation

John Lister

For the first 26 years of its life after it was launched on July 5 1948 the NHS was hardly changed in structure. But since 1974 a regular churn of reorganisations and structural adjustments has consumed huge amounts of management time and energy, often with highly questionable results.

In 1948, when the NHS in England and Wales was run jointly, there were 377 hospital management committees, and 36 teaching hospitals with their own board of governors, while health centres, ambulance services and other community services were run by 146 local authorities, and general practices, NHS dentistry, pharmacists and opticians were run by 140 executive councils.

The 1973 NHS Reorganisation Act was drawn up by Ted Heath's Tory government and implemented in 1974 by Harold Wilson's Labour government.

Local focus

It brought the first real focus on more local accountability and involvement of the public in the decisions on health care, and established a 3-tier system of Regional, 90 Area and 205 District Health Authorities (reducing to 199 by 1979).

It also integrated ambulance services, and some community services, previously run by local government, into the NHS for the first time. Primary Care was still run and financed separately through Family Practitioner Committees.

In 1976 a monetary crisis forced Harold Wilson's Labour government to seek support from the International Monetary Fund: one of the strings attached obliged ministers to cap NHS spending at local level. As a result hospital and mental health services (but not primary care) were subjected to formal "cash limits," and Margaret Thatcher's government made these cash limits legally binding in 1980.

The next reorganisation followed in 1982, in which the Area Health Authorities were abolished, and district health authorities were restructured.

Thatcher's review

In 1988 Thatcher launched a secretive "review" of the NHS by a hand-picked team of advisors, whose plans surfaced as the NHS and Community Care Act in 1990.

The Act, strongly opposed by the BMA and in parliament, slashed the number of DHAs from 190 to 145 by 1993 with plans to further reduce to 108 by April 1994 and eventually to as few as 80-90, raising questions over lost local accountability.

It split the NHS for the first time into purchasers (District Health Authorities, with cash-limited budgets based on local population, and 306 "GP Fundholders", with their own budgets to "shop around" and purchase elective treatment for their patients) and providers.

Five years later the Health Services Act reorganised the 14 regional health authorities into 8 – and scrapped the FHSAs that had just been established.

Paul Marriott/Alamy

Margaret Thatcher's 1989 'review' led to the "internal market"

Jane Wiedel/Alamy

Campaigning against the Health and Social Care Act, 2011

Tony Blair's victory in 1997 was followed by a new policy statement "The New NHS, Modern, Dependable," – but no new money.

GP Fundholding, which had left a minority of GP practices holding substantial unspent funds, was scrapped in 1998, in place of which 481 Primary Care Groups were established as advisory bodies to District Health Authorities.

In England from 2000 Primary Care Trusts (PCTs) began to be established, with up to 300 eventually agreed. As PCTs developed they replaced DHAs as hybrid bodies, commissioning local services, while also providing community health services.

Cash limits extended

New Labour's NHS Plan also brought in the cash-limiting of GP services which had until that point been the only sector of the NHS not subject to spending constraints.

Numbers of PCTs were halved to 151 as a result of the controversial "Commissioning a Patient Led NHS" reorganisation from 2005 which deepened the purchaser-provider split.

It required PCTs to separate themselves from community services and contract them out, inviting tenders from "any willing provider" – until in 2009 Andy Burnham as Health Secretary stepped in and, under pressure from the unions, brought a temporary halt to the privatisation by insisting that NHS trusts should be the 'preferred provider'.

A year later the Cameron coalition took office and immediately launched into the biggest-ever top-down reorganisation of the NHS.

Lansley

Health Secretary Andrew Lansley's disastrous market-based reorganisation in 2013 scrapped both PCTs and the remaining SHAs, and established 207 Clinical Commissioning Groups (CCGs) with no regional coordination, headed by NHS England. Regulations required the CCGs to put an increasing range of clinical services out to competitive tender.

In 2014 Simon Stevens, one of the movers of New Labour's marketising "reforms" from 2000, was appointed CEO of NHS England.

He swiftly published the Five Year Forward View, which barely mentioned competition, and which first introduced the notion of Accountable Care Organisations (ACOs) to the lexicon of British health care reorganisation, coyly referencing its origins in the chaotic US health care system.

At the very end of 2015 the emphasis switched from the Five Year Forward View to the establishment of "Sustainability and Transformation Plans," which were to be drawn up across 'local health economies' at breakneck pace behind closed doors by NHS

As services have since been brought together, the competitive market has also split them up into contracts and brought rivalries rather than collaboration

chiefs, where possible with token involvement of local government.

During 2016 England's NHS was carved up into 44 STP areas, each of which set up extra-legal bodies to drive the implementation of plans that not only lacked any popular or political support, but which in several cases proved completely impractical.

42 ICSs

Nonetheless the STP 'footprint' areas, with some adjustment in the north of England, have become the 42 areas now to be redesignated as Integrated Care Systems, to be given statutory powers under the new health and Care bill.

However there is still no real clarity over the extent to which the previous boroughs/CCG areas ("places") will continue to have any voice over policies decided by the most remote-ever "local" management bodies.

One obvious conclusion from this constant churn and redisorganisation is that there is no past golden age to which we can neatly restore the NHS.

The period prior to 1974 gave little or no voice to local communities, with the NHS still not including ambulance or community services, and with primary care very much separately controlled.

But as services have since been brought together, the competitive market has also split them up into contracts and brought rivalries rather than collaboration between NHS providers.

The challenge is for campaigners to find enough common cause to combine once more with opposition parties and the unions to defend the NHS against the latest new threat.

NEXT ISSUE

Our next issue of the news bulletin will be in September. Please get any articles, photos, tip-offs or information to us no later than SEPTEMBER 1.

PA Images/Alamy

Will any of Stevens' successors be willing to take the fight for adequate funding into the public domain?

Who will be next NHS England boss?

John Lister

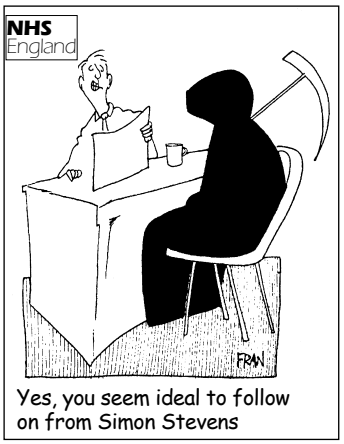
An "overseas healthcare leader" has apparently been added in to the mix as a fifth shortlisted candidate to take over from Lord Stevens of Birmingham as chief executive of NHS England.

This comes after hotly-tipped but serial incompetent ex-jockey Dido Harding's chances fell away with the disgraced departure of her buddy and biggest fan Matt Hancock from his post as Health Secretary. His newby replacement, clearly under the thumb of Boris Johnson, is reportedly not close to Harding, and unlike Hancock doesn't represent a horse racing constituency.

HSJ reports a potentially strong candidate, Sir Jim Mackey, former chief executive of NHS Improvement has also dropped out of the race. This leaves the most strongly-placed 'inside' candidate as Stevens' virtual deputy at NHS England, Amanda Pritchard.

She is widely described as an experienced senior manager having been chief executive at Guy's and St Thomas's Hospitals FT: however her period at amongst the higher echelons of the NHS seems to have severely limited her communication skills. When she presented a complex framework of more than 70 metrics for assessing Integrated Care Systems to NHS England's Board, the HSJ reported her speech as follows:

"This is a really important building block of our kind of architecture as we move towards much more kind of delivery through systems but also brings us right up to date with the priorities we have committed to in the long term plan."



Yes, you seem ideal to follow on from Simon Stevens

This fluency in gobbledygook seems to be a strong basis for suggesting she is ready to step in to Stevens' shoes.

Outsiders

The other three known candidates are all from outside the current NHS, although Mark Britnell, for many years now a senior partner of management consultancy KPMG, was once NHS Director General of Commissioning during the New Labour years.

He left the NHS as times began to get tough in 2009. He became a "kitchen cabinet" advisor to David Cameron's government in 2011, but was subsequently revealed to have boasted to a US audience that the Health and Social Care Act would "show no mercy" towards the NHS and offer big profits to the private sector.

Leeds City Council chief executive Tom Riordan has held that post since 2010, but according to Wikipedia he spent 3 months in 2020 working for the government on the test and trace system – and appears to have liked it.

The most recent addition to the public list has been Douglas Gurr, a former McKinsey partner who spent four years up to 2020 running Amazon's operation in the UK, which famously contributes little or no tax revenue towards funding the NHS – although it makes substantial demands on it.

Mr Gurr will have been the manat the top when according to the GMB union in early 2020 'hellish' working conditions for Amazon's warehouse employees were so tough that there had been more than 600 ambulance call-outs to Amazon warehouses over the past three years. The GMB is still calling for a parliamentary inquiry into Amazon.

It's unlikely that any of Mr Gurr's expertise in this style of human resources will be of any help to an NHS facing a chronic workforce shortage exacerbated by burn-out and stress after the long battle against Covid-19. The HSJ reports Mr Gurr has been a non-executive on the Department of Health and Social Care's board since 2018.

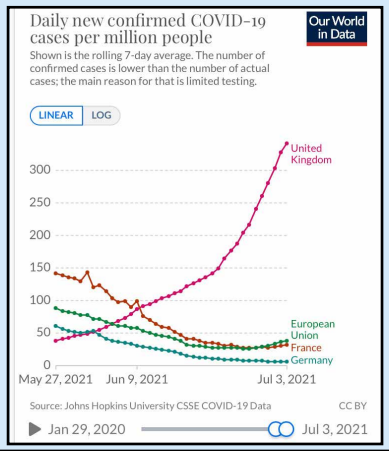
"Freedom Day" July 19

Ministers are gambling with our lives

On July 13 Health Secretary Sajid Javid confirmed in the Commons that there would be no delay to the July 19 "Freedom Day" plan to relax most Covid restrictions in England.

The same day it was revealed that the number of covid-positive patients in English hospitals had risen by 48 per cent in the previous week alone, to 2,798, a rate of increase not seen for nine months.

Hospitals are re-opening Covid units and once more having to cancel waiting list operations, while ministers assure the public that the NHS will not be overwhelmed by their latest irresponsible decision



– which is clearly more driven by the ill-informed antics of Tory back benchers than by clinical data.

Patients include those (mainly young) who have declined vaccination, and people who have had just the one dose.

The link between infection, hospitalisation and deaths has not yet been broken.

The following day new Covid infections reached 42,302, higher than any day since January 15.

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.

Mayors have begun to invoke what powers they have, and urge government to insist that masks will legally have to be worn on public transport in London and other big cities, while ministers issue mixed messages.

Let's all be careful out there!

KONP People's Covid Inquiry ends with seven immediate recommendations

On July 7 a conference held to conclude the public hearings for KONP's People's Covid Inquiry presented its initial "manifestly obvious" findings, and those the Panel agreed require urgent action.

The meeting was opened by Panel Chair Michael Mansfield QC, who on behalf of the Panel paid tribute "to the courage and commitment of the citizens of the UK many of whom have given evidence to our Inquiry and who have shown endless, selfless support to their fellow citizens in the most challenging and extreme circumstances."

The key initial recommendations were then briefly explained:

Recommendation 1

That established public health measures, supported by the WHO and known to be effective in lowering everyday risks, be urgently implemented in the UK, including:

(a) effective find, test, trace, isolate services with economic support for isolation and quarantine;

(b) based in local public health and local authorities in liaison with an effective national public health system

(c) with effective protection against aerosol transmission by the wearing of masks and sensible social distancing in enclosed indoor spaces

(d) employment of strict border measures for infection-control purposes

Recommendation 2

That medium to long-term health policy addresses social inequality, including overcrowding, poor quality housing, food insecurity, investing in recovery that tackles the root causes of health inequalities

Recommendation 3

That the UK fulfils its international obligations to prevent the spread of disease by ensuring global distribution of vaccines and support for technology transfer and IP waiver, and by the termination of vaccine nationalism.

Recommendation 4:

The pandemic provides both rationale and opportunity to invest in the NHS and a public sector health and care service that could once again be the envy of the world; the UK did this in 1948 and can lead the world again now.

This investment includes not only hospital beds, but the workforce, primary care, diagnostic labs, social care, and public health).

We do not dismiss the private sector, but to promote it in favour of the public sector does the nation a huge disservice and weakens us for the future.

Recommendation 5

That it is possible, and urgent, to restore and grow NHS capacity and NHS staff morale with a statement of commitment to public services, backed up by urgent real terms restoration of level of funding to expand the NHS workforce and reinvigorate the publicly provided NHS and its workforce.

Recommendation 6

That the previously universally admired performance of the NHS can be restored if the Government ends its policy of bypassing and undermining public services in favour of contracts to the private sector on procurement and to provide clinical services for NHS patients in place of NHS provision.

Johnson has refused to hold an inquiry now, when it matters most

Recommendation 7

An independent public Judicial Inquiry is needed NOW

"For four months the People's Inquiry has steadfastly ensured that the voices of the bereaved, the experts and the citizens on the frontline have been heard, recorded and acknowledged.

"For four months we have done the job declined by the PM and which he has no real intention of carrying out when it matters most - which is right now - not when it is politically convenient for him some year in the future."

The Panel comprised **Michael Mansfield QC** in the chair**; Professor Neena Modi** Professor of Neonatal Medicine, Imperial College London and president, UK Medical Women's Federation; **Dr Tolullah Oni** Urban Epidemiologist & Public Health physician, Univ. of Cambridge; **Dr Jacky Davis** NHS consultant radiologist, author, BMA council member.

The Counsel to the Inquiry was **Lorna Hackett,** Barrister, (Hackett & Dabbs LLP).

US firms dominate pharmacy market

The announcement by Boots at the end of June that they are opening up "online doctor" services to cover 45 healthcare conditions, backed up by Boots' network of 2,400 physical shops, is a reminder of the continued expansion of privatisation into general practice.

According to statistics published monthly by NHS Digital, the percentage of remote consultations in England rose dramatically in the first wave of the pandemic, going from 14% of all consultations in February 2020 to 48% in May of the same year.

However by October 60% of appointments had reverted to face to face, while online appointments accounted for just 5%, compared with 35% of remote consultations over the phone.

But the scale of the Boots operation also puts into context the expansion of US corporation Centene into primary care, which with their recent acquisition of 49 practices from AT medics became the largest single private provider of NHS GP services.

It also reminds us of the extent of US penetration of the market for pharmacies: Boots is owned by Walgreens Boots Alliance, while 1,500 Lloyds pharmacies are owned by McKesson, and Asda's 250 pharmacies are owned by Walmart.

The current likely takeover of Morrisons, which has over 100 pharmacies, by another US corporation, Fortress, brings the US-owned total to around a third of all UK pharmacies.

By comparison the ownership of fewer than 2,000 community pharmacies are UK based, with the most prominent being 760 Well Pharmacies (owned by Bestway) and 450 Tesco pharmacies.

Inquiry reveals scale of harm done by "hostile environment" charges

Patients have suffered as a result of the charging practices at Lewisham and Greenwich NHS Trust (LGT), a report published Friday 25th June has revealed. It concludes an inquiry set up by the Trust in November 2019 into its arrangements for charging patients who are ruled ineligible for NHS treatment and care at the Trust by law.

The inquiry was set up in response to public outcry from campaigners and local authorities over the Trust's practices, and as a result of public revelations in the Health Service Journal of the Trust's use of credit reporting company Experian.

Despite the vulnerable status of many patients, the inquiry revealed a lack of compassion and empathy from Trust staff towards their situations, causing significant distress.

In one case study submitted to the inquiry, a patient retold how they screamed and fell to their knees when they received their invoice for £15,480 for life-saving maternity care. At the time, this patient was living in supported accommodation and had no income.

Another patient told the inquiry how their blood pressure rose after hearing they were being charged for their stay in hospital.

The news was delivered just hours after giving birth and they were forced to extend their time in the ward as a direct result of the impact of the £6,000 charge on their stress levels.

Threats every day

One patient, interviewed by Lewisham Refugee and Migrant Network, said: "I was charged about £7,000. I was staying in one room accommodation and I couldn't even afford a payment plan to pay back the debt. There were threats that they were going to report me to the Home Office and I received calls every day. This was at the same time that my child was diagnosed with autism."

Some also reported being afraid to pursue healthcare after their experiences, suggesting that the Trust's practices endangered lives, violating the NHS' core purpose.

The report outlined 39 recommendations to improve the Trust's NHS charging practices, the majority of which were accepted.

These include reviewing and improving their patient literature to clarify the regulations, writing off debt for people facing destitution, and committing to training on the impact of the charging legislation on patients.

In a joint statement, Lewisham Refugee and Migrant Network and Save Lewisham Hospital Campaign said:

"We have participated in the panel in order to reduce the harm of the policy. But we remain completely opposed to the legislation that is part of the continuing Hostile Environment and which we believe will continue to harm patients in the future. Organisations such as ourselves and many others will continue to campaign to end these charges once and for all."

"We recognise that NHS staff have to comply with this discriminatory and harmful legislation, targeted at undocumented and vulnerable people, and we welcome measures the Trust has now taken to minimise the damage the policy causes."

In the report, the Lewisham and Greenwich NHS Trust said:

"The Trust sincerely regrets, and apologises for any instances where patients were not treated with compassion, or in a manner consistent with the values of Trust."

South Tyneside to lose children's A&E from August 4

According to BBC Newcastle on July 14, visiting at Sunderland and South Tyneside hospitals has ceased as Covid cases rise and staff struggle to cope.

Nonetheless the Trust is pressing ahead with the downgrading of services at South Tyneside Hospital in South Shields that has been accelerated by the merger of the two former trusts.

The next target in the sights is Children's A&E, which will be replaced from August 4 by a nurse-led "urgent care" services for children, with any more serious cases having to travel to Sunderland Royal Hospital, seven miles south.

Stroke treatment and overnight children's A&E have already moved to Wearside, despite angry protests from South Shields MP Emma Lewell-Buck, and from the Save South Tyneside Hospital Campaign, who in June sent a delegation to London to present a petition to Parliament bearing 44,000 signatures against the moves.

Roger Nettleship, chairman of the Save South Tyneside Hospital Campaign says that according to a 2017 document the move was aimed to make savings of around £200,000.

HEALTH CAMPAIGNS TOGETHER #our NHS

Ministers try to sneak through new prescription charges

Ministers have marked the 73rd anniversary of their party voting against establishing the NHS by launching 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.

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 saddle those who have already lost out with prescription charges – which have just risen again to £9.35 per item.

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.

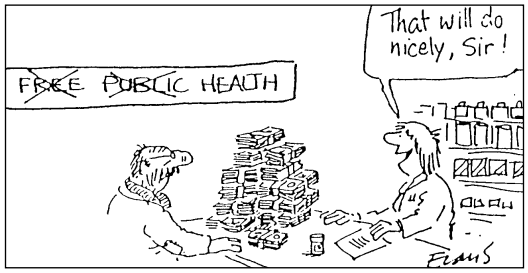
England is the only country in Britain still paying prescription charges, which were abolished by devolved governments in Wales (2007) Northern Ireland (2010) and Scotland (2011).

In each case the limited 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 back in 1948.

Experience disproved Tory claims then 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).



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 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.

A 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.

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 up-front payments or pay singly for prescriptions.

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.

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.

Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an **alliance** of organisations. We ask organisations that want to support us to make a financial contribution to facilitate the future development of joint campaigning. **WE WELCOME SUPPORT FROM:**

- **TRADE UNION** organisations – whether they representing workers in or outside the NHS – at national, regional or local level
- local national NHS CAMPAIGNS opposing cuts & privatisation
- pressure groups defending specific services and the NHS,
- pensioners' organisations
- political parties – national, regional or local

The guideline scale of annual contributions we are seeking is:

- **£500** for a national trade union,
- **£300** for a smaller national, or regional trade union organisation
- **£50** minimum from other supporting organisations.

NB If any of these amounts is an obstacle to supporting Health Campaigns Together, please contact us to discuss.

You can sign up online, and pay by card, bank transfer or by cheque – check it out at at *https://healthcampaignstogether.com/joinus.php*

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