THE lowdown

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

NHS kept on a short leash

The *Health Service Journal* has picked up the tough new Department of Health and Social Care regime aimed at gagging "arm's length" NHS bodies that reveal the scale of the problems posed by Brexit.

Headlined 'DHSC slaps down quangos over Brexit messages,' it quotes from a leaked email from DHSC director of communications Rachel Carr, angry at a story in the media about the NHS Blood and Transplant Authority cancelling blood donation sessions, arguing:

"This was not cleared either through the EU exit comms team, at DHSC or through the secretary of state."

So-called arm's length bodies include the Care Quality Commission, NHS England, NHS Improvement, Public Health England and the National Institute for Health and Care Excellence

This latest shot across the bows shows that they are not really at arm's length at all, but on a short leash, and under the thumb of ministers and Department bureaucrats.

"No privatisation" promise under strain from multi-billion NHS outsourcing plans

Paul Evans

Private companies are in a 3-way fight for the biggest ever NHS pathology contract, just a month after the health secretary committed to prevent NHS privatisation.

Labour has identified a further £128million NHS tenders in the pipeline and is calling for Matt Hancock to step in "to keep them in public hands"

It emerged this week that private companies are involved in each of the three bids to supply pathology services to a group of hospitals in London and across the South East, making it very likely that the new service will be outsourced. The £3bn contract is the largest of its kind and could run for 20 years.

Also this week, NHS England granted private provider Babylon Health the right to extend their digital GP at Hand service into Birmingham, despite objections from GP leaders and before a review can present its conclusions.

In a further development research for the Labour party has identified 26 NHS tenders that have been advertised and it has accused the Health Secretary of going back on his recent "concrete" commitment, before a committee of MPs, that there would be "no privatisation on my watch".

Mr Hancock's statement had seemed to be part of a choreographed move away from market-based solutions within the NHS. It followed a call from NHS England, for ministers to abandon the controversial competition rules, a request that was written into the Long Term Plan and signed off by Downing Street.

However, despite the apparent accord between the NHS and ministers on the competition regulations, they remain in place. NHS commissioners are obliged by law to advertise many larger NHS contracts, giving firms like Virgin Care the chance to bid.

Figures from the NHS Support Federation show that since these rules came into place over £25bn worth of NHS contracts have been advertised and nearly 40% of them have been won by the private sector.

"This Health Secretary's privatisation credentials become clearer by the day," says Labour's Jonathan Ashworth

In comments to the Press Association Labour's health spokesperson Jonathon Ashworth said

"This Health Secretary's privatisation credentials become clearer by the day, whether it's promoting GP at Hand to endorsing private dentistry to now allowing millions of pounds worth of health services contracts to be privatised,"

A Department of Health and Social Care spokesperson responded:

"We're committed to providing world-class NHS services that are always free at the point of use and are investing £20.5 billion a year extra by 2023/24 to guarantee the future of our health service through the NHS Long Term Plan.

"These decisions are clinically-led by NHS experts and based on what's best for patients."

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Biggest ever pathology contract to go to private bid

A contract for to set up the largest ever pathology network was launched In September 2018 and this week news about the shortlist of bidders makes it very likely that it will go to a private provider.

Eight hospital trusts advertised a pathology contract worth £3bn over 20 years, which aims to link services as part of new hub and spoke network. The *Health Service Journal* published details of the three shortlisted bidders, but their names have not been confirmed by local commissioners. They are:

- Health Services Laboratories (a joint venture between the Royal Free London Foundation Trust, University College London Hospitals FT, and The Doctors Laboratory)
- Synlab Group
- Incumbent provider Viapath (a joint venture between Guy's and St Thomas' FT, King's College Hospital FT and Serco)

The network will serve at least 8 trusts across London and the South East. The scale of the procurement was set after a review from Lord Carter identified potential savings of £200m from setting up a hub and spoke networks, linking services together.

The hub hospitals will provide more complex services whilst the smaller hospitals focus on simpler pathology work for their own hospital.

The existing contract is currently held by Viapath, a company owned by Serco and the two trusts, who have already transferred NHS staff to work for them. If they won, the new contract would expand this arrangement.

The contract will be awarded in September, and the new service is expected to be in place by September 2020

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Lewisham and Greenwich Trust has refused to be part of the procurement because it is considering a solution that keeps its pathology provision within the NHS.

Commenting on the procurement Sarah Cook health lead for Unite London and Eastern region, who have members in many of the trusts involved said

"We have concerns about the protection of jobs and whether this is extending privatisation by the back door. We would support bringing these services back-in house."

The eight trusts involved are:

- Guy's and St Thomas' FT
- King's College Hospital FT
- East Sussex Healthcare Trust
- Epsom and St Helier University Hospitals Trust
- Oxleas FT
- South West London and St George's Mental Health Trust
- South London and Maudsley FT
- Royal Brompton and Harefield FT

How long will Interserve survive?

Just over a year after the collapse of leading contactors Carillion with job losses and disruption, another multinational support services and construction company, Interserve, is struggling for survival.

Interserve is UK based, and had revenue of £3.25 billion in 2017 and a workforce of more than 75,000 people worldwide. 70% of its turnover is from UK government projects and contracts, including support services in NHS hospitals and social care.

Interserve Healthcare provides staff for both NHS and nursing/care home facilities; it also provides complex care both in a home and community based setting.

It operates through a network of 26 branches and works with CCGs, Social Services, private and NHS hospitals, nursing homes and learning disability establishments as well as delivering care to private clients in their own homes.

However like Carillion, Interserve's dividends to shareholders grew faster than its actual profits and by 2017 it was reporting a loss of £254m, more than double the 2016 loss of £102m.

No lessons have been learned from Carillion collapse

To cover dividend payments and losses Interserve borrowed heavily, with long term debts of £807m in 2018: interest charges are ncreasing on these debts and the firm also owes its pension scheme £48m.

Despite ministerial assurances in January 2018 that Interserve was "not another Carillion" it's clear that no lessons have been learned from that collapse.

The company's survival after a bail-out deal earlier this month that involves cutting its debts from over £600m to £275m by issuing new shares.

The rescue deal hangs on the willingness of banks to prop it up, and hold on to shares that will generate little if any return.

Interserve retains a portfolio of low margin contracts and continuing losses. How long can that continue?

Profits Spiralling down

Despite moves by many Clinical Commissioning Groups to draw up ever longer lists of treatments that are not to be routinely funded by the NHS – effectively pushing more patients towards the choice of going private or going without– it seems the private hospitals are struggling.

Patients without insurance remain reluctant to self-pay for private treatment.

Spire Healthcare, Britain's second largest private hospital company with 39 hospitals and 11 clinics, is blaming reduced numbers of NHS-funded patients, and a likely increase in staffing and other costs after Brexit for a continued worsening of its finances and prospects.

Last September the firm noted the "unprecedented decline (both in scale and speed)" of NHS funded admissions: its adjusted pre-tax profits more than halved to £16.4m in the six months ended June 30.

Swiss Bank Credit Suisse has downgraded its rating for Spire, in the expectation the market for private healthcare will get worse again in 2019.

So at least there is some good news to relieve the general gloom.

Priory-owned hospital closes after critical watchdog report

A hospital for young people with learning disabilities owned by the private mental health company, The Priory Group, has been closed following a CQC report that put it into special measures.

The regulator's report was damning, with an overall 'inadequate' rating and a conclusion that the hospital was "not adequately equipped to care for young people with complex needs".

The Priory has now closed the hospital, based in High Wycombe, and moved the patients to other units. The hospital only opened in April 2018.

Pauline Carpenter, Head of Hospital Inspection (and lead for mental health) at the CQC, said:

"Our inspection has identified a number of serious problems concerning patient safety and the quality of care that needed immediate attention.

"It was a matter of some concern that, at a specialist unit, some of the staff could not demonstrate the knowledge or specialist skills needed to care for teenagers who had learning disabilities or autism.

Shocking

The inspection reported a number of shocking findings, including a young person with complex needs who managed to swallow objects such as screws, wire and a part of a radiator grill; medication errors; no access to psychological therapies for the patients; and the layout of the ward itself being unsuitable for young people with autism as it was disorientating and noisy.

The company is owned by the US company Acadia and had reported income of £796.6 million in 2017

This damning CQC report comes hard on the heels of The Priory pleading guilty to health and safety charges following the death of 14 year old Amy El-Keria in 2012.

The case, which was heard in Brighton Magistrates Court in January 2019, could result in a fine of more than £2 million for the company, according to a report in the HSJ.

In 2016, an inquest ruled that the death of a 14 year old Amy El-Keria in 2012 at Ticehurst House, a Priory hospital, was as a result of months of serious failings at the hospital, including staff failing to pass on the fact that she had spoken of wanting to end her life. The inquest also ruled that staff failed to dial 999 quickly enough and failed to call a doctor promptly.

Responding to the guilty plea, Amy's mother Tania El-Keria said:

"Amy's mental health care should never have been in the hands of a company whose priority was placing profit over her safety. For 14 years we kept her safe but within 3 months with the Priory she was dead."

The Priory Group, which operates as both The Priory and Partnerships in Care, is a leading provider of mental health services to the NHS.

The group's services include in-patient and out-patient services that cover a wide range of psychiatric conditions, including drug and alcohol rehabilitation, plus learning disabilities.

The company is owned by the US company Acadia and had reported income of £796.6 million in 2017.

The Priory has been the subject of several reports of failures in care in recent years, including other patient deaths.

Early in 2016, the family of 17-year-old Sara Green, who died in the Priory Royal in Cheadle in 2014, called for the company to have its NHS contract cancelled.

Then in March 2016, the Priory and Solent NHS Trust admitted liability for the death of 15-year-old George Werb, who had been a patient at the Priory Hospital Southampton.

No workforce plan = no plan at all

One of the striking omissions from NHS England's Long Term Plan published last month was of course the lack of any workforce strategy as the number of unfilled vacant posts has risen above 100,000, and many key services are finding it hard to recruit and retain the staff they need.

A major new report on staffing from the Health Foundation highlights some of the issues that NHS England and the government have to get to grips with if there is to be any serious effort to resolve a major and growing obstacle to maintaining viable services.

It notes a small scale (less than 2%) overall increase in staff numbers which is nowhere near enough to meet the needs for more nursing and professional staff.

There was less than a 1% increase in numbers of midwives and an even smaller (less than half a percent) increase in nurses and health visitors, although this masks an actual reduction in numbers of health visitors. Mental health nurse numbers have risen by less than 0.5% despite the government's 2017 promises to recruit an extra 21,000 mental health staff.

Numbers of GPs have also fallen, again despite promises in the GP Forward View back in 2016 to recruit an extra 5,000 GPs by 2021.

GP Online has now reported that a major international recruitment drive that aimed to recruit 2,000 GPs managed to produce just 34 GP recruits in three years. The chances of improving on this have of course been systematically undermined by Brexit and the government's high profile "hostile environment" policy on immigration.

The Health Foundation report highlights the lack of any coherent government approach to the recruitment of professional staff from overseas, and in particular the need to include allied health professionals to the "shortage occupation list" since many of them earn less that the minimum £30,000 salary floor required to gain entry to the UK.

Crisis is the new normal – UNISON survey

Crisis level staffing has become the norm across the NHS, according to a worrying new UNISON survey of over 16,000 staff.

The snapshot was based on just one working day – Tuesday September 18 – before any winter pressures added to problems.

Almost two thirds (59%) of 2,345 staff responding who worked in acute inpatient services reported that staffing levels were insufficient.

Almost half (45%) of mental health staff, 41% of primary care staff and more than a third (36%) of community health staff raised the same concerns.

Almost half of all the staff responding said that services relied on bank staff to fill

nursing roles and work as healthcare assistants, admin and clerical and other jobs.

Almost one in six (15%) felt patient safety was compromised by staff shortages on the day of the survey. 38% reported working longer than their scheduled hours, many of them unpaid, on the day of the survey.

Other responses help point to reasons for the problems recruiting and retaining vital staff.

One in six (16%) of the staff in all posts reporting being subjected to violence, aggression or verbal abuse on the day of the survey, and more than a quarter (26%) reported high levels of stress.

UNISON is calling for legislation to ensure mandatory safe staffing levels in England and Northern Ireland, following on similar measures that have been implemented in Wales and broadly similar proposals being passed through the Scottish parliament.

Counting cost of lost bursaries

The Royal College of Nursing is also pressing for a legal enforcement of safe staffing levels.

It has highlighted the long-term damage caused by the government's short-sighted effort to save money by axing NHS bursaries for the training of nurses and other professional staff which is now beginning to show through.

The RCN has revealed that nursing degree applications are down by a massive 30% since 2016 – the last year students received the bursary payments.

2018 was the second year in a row in which numbers of applications fell.

The largest decline in numbers is the 41% reduction in applications from mature students (aged 25 and over).

Across the UK almost a quarter (24%) of students starting a nursing degree dropped out or failed to qualify within the expected time.

Mature students, most of them returning to learning after some years of employment, are most likely to complete the course – but also the most likely to require bursaries to help support families and compensate for loss of earnings.

Brexit blow to social care

Problems recruiting sufficient staff to deliver social care services are likely to increase sharply with Brexit according to the Association of Directors of Adult Social Services (ADASS). One sixth of the 1.3 million workforce in social care come from overseas, comprised of an estimated 100,000 EU nationals and another 100,000-plus non British workers.

In a letter to London's *Evening Standard* ADASS point out that the proposed £30,000 minimum salary level for migrant workers to be allowed in to Britain would effectively block entry to new recruits and leave nursing homes and domiciliary care companies struggling to keep services running.

The problem is of course worsened by the absurdly low levels of pay prevalent in social care services.

Insulin users at risk in no deal Brexit

This month as seen an impassioned call from a diabetes charity to the government to guarantee the supply of insulin in the event of a crash-out Brexit.

The InDependent Diabetes Trust says the government is "gambling with people's health" as Brexit could severely impact on the availability of insulin supplies - this is a life or death situation for the thousands of insulin-dependent diabetics in the UK."

Insulin has hit the headlines as nearly all supplies in the UK are imported, mainly from Denmark. The drug needs to be refrigerated and cannot be kept waiting in traffic jams at ports.

If the UK crashes out without a deal in a few weeks time, there are real concerns over supply.

Without insulin diabetic patients could be dead within 48 hours.

Jenny Hirst, co-chair and co-founder of the organisation, said:

"While everyone is getting sick of the whole Brexit debate, insulin-dependent people with diabetes will actually become seriously ill if a no-deal disrupts supply of the life-saving drug.

"MPs need to realise that they are gambling with people's health. The party political games, the Tory euro infighting, the jousting for the top jobs, it all needs to stop. They all just need to come together to agree a deal to avoid any disruption to essential supplies."

Hardcore Brexiteers dismiss it all as propaganda generated by "project fear" Europhile campaigners. They have said the UK can just import from the USA or elsewhere.

This of course, does not take into account the difficulties that will be faced at ports amidst the chaos of the predicted lorry queues or the requirement for a specific type of insulin.

Right to worry

Mark Dayan, a policy analyst at Nuffield Trust, told the ***Washington Post***, that government preparations "would probably prevent … really widespread shortages immediately."

Still, he said, "People are probably right to worry."

Also, for diabetics one insulin cannot simply be swapped for another; there are several types. Each patient has a particular treatment regime, involving different devices and types of insulin.

Each regime is finely-tuned to regulate the patient's blood glucose levels to ensure the health of the patient. The development of the patient's regime can take months or even years to perfect. It cannot be changed at a moment's notice without harming the patient's health.

There are concerns for many drugs used by the NHS; about half are imported from or "have some touchpoint with the EU", according to the Health and Social Care Secretary Matt Hancock.

He should know: he claims his department have been through line-by-line analysis of the 12,000 licensed medicines in the UK. Last month he made it clear to the Health and social care Select Committee that medicines will take priority over food in a no deal Brexit scenario.

Private digital GP service given go ahead to attract more NHS patients

Paul Evans

Digital GP services run by private provider Babylon have been given the green light to expand into Birmingham and add to the 40,000 NHS patients that it has so far recruited from its West London base.

In a U-turn NHS England has lifted its block on the company expanding the service. It was imposed following complaints from local CCGs that the digital GP service was cherry-picking younger, fitter patients and undermining other local services.

Babylon GP at Hand provides video appointments with a GP within 2 hours and diagnosis tools though its own app. It is not suitable for many patients who need face-to-face care, but has proved attractive to younger NHS patients and 40,000 have signed up, leaving their local GP.

Permission from NHS England to extend the service appears to pre-empt the publication of an independent review into GP at Hand, which it commissioned and is due to be published in March.

Concern has already been voiced that investigations into the service are not robust enough.

Researchers IPSOS MORI admitted in a preliminary report that they would not be able to fully evaluate the safety and effectiveness of the service.

BMA GP Committee chair Dr Richard Vautrey told *Pulse*:

'We are incredibly disappointed with this decision, which is not only premature, but flies in the face of place-based care delivered by practices embedded in local communities, which the recent changes in the GP contract are committed to deliver.'

Babylon has welcomed the decision and hinted at further plans to go countrywide with their digital GP service.

Under the government's GP choice scheme patients are able to apply to register with any participating GP practice away from home. Figures from NHS England show that most practices have no out of area patients at all. Babylon are using the scheme to compete for NHS patients, registering tens of thousands of new patients as 'out of area'.

The Health Secretary, who is himself signed up to the GP at Hand service has made digital solutions a key priority, but has been criticised for appearing to offer his personal backing to Babylon, which Labour suggests breaks the ministerial code.

Prior to this week's announcement it had appeared that Babylon's plans were being curbed, as recent rule changes restricted the rewards that the company could earn for registering new patients.

However, the permission to extend the service has invited new criticism that the digital service is being unfairly supported by the government.

According to reports in the *Telegraph* Babylon Health already has plans to expand GP at Hand into Southampton, Manchester and Leeds.

In Birmingham the clinical Commissioning Group that had originally objected to Babylon is now backing the service. Paul Jennings, the CCG's chief executive told *Digital Health*:

"Working in close collaboration with our GP provider organisations, we are supporting the development of a local digital offer that will help to transform the lives of our 1.3 million patients."

Q&A: Who is Babylon Health and what is it doing within the NHS?

Babylon Health has made headlines in recent months through its work within the NHS on developing digital technology and the use of its GP at Hand smartphone app.

By Sylvia Davidson

Who started the company?

Babylon Health was founded in 2013 by former investment banker Ali Parsa, who until December 2012, was CEO of Circle Health. Circle Health was the private company that was awarded a ten year contract to run Hinchingbrooke Hospital in 2012 and abandoned it three years later in 2015.

What technology has Babylon Health developed?

The company has developed a smartphone app which is designed to answer medical queries through the use of a question and answer format. The app can then put the user in-touch (virtually) with a GP. Babylon says the technology is a form of artificial intelligence (AI).

The app can be personalised by the use of a dashboard of the user's health statistics (exercise regime etc.) acquired either by the phone or via supplemental devices. Babylon will supply users with blood testing kits for liver and kidney function, thyroid function, vitamin levels, bone density and cholesterol. The results of the tests are then incorporated into the user's app settings.

In the UK, the company also offers a private service via its app; the service has a subscription charge plus extra costs on top, such as £25 for a remote GP consultation.

Babylon's primary target in the UK, however, is gaining access to NHS patients. The company has a contract with NHS England for its app under the name GP at Hand. The service was launched in London in 2015 and expanded in 2017. Over 40,000 patients are now registered with the GP at Hand app.

What does Babylon Health do in the NHS?

Babylon Health has a contract with NHS

England to register patients to the GP at Hand app. The contract is through the GP surgery of Dr Jefferies and Partners, based in Lillie Road, Fulham in West London. All patients who sign up with GP at Hand are registered at this Fulham surgery.

If patients registered with GP at Hand need to see a GP or nurse in person they must make an appointment at the Lillie Road, Fulham surgery or at one of four other surgeries in central London.

All patients who sign up with GP at Hand must de-register from their own NHS surgery and re-register with the Fulham practice. Under the Government's 'GP Choice' scheme, this surgery can sign up patients outside its traditional boundaries.

As a result, Babylon has been able to target patients who live across London and those who work in zone 1 to 3.

Since the company began its NHS England contract, over 40,000 patients have registered at this single Fulham surgery. The company promises that patients will be able to 'book an appointment within seconds' and have 'a video consultation with an NHS GP typically in under two hours of booking, anytime, anywhere'.

Initially, GP at Hand could not register certain groups of patients, but in November 2018, NHS England lifted all restrictions on the type of patient that can register with GP at Hand.

In February 2019, NHS England cleared the way for GP at Hand to expand to Birmingham. Patients who sign up in Birmingham will also be registered at the Fulham surgery in London, although the company will have a physical clinic in Birmingham.

What concerns surround Babylon Health?

Cherry-picking

Both the RCGP and BMA have criticised Babylon for 'cherry picking' younger, healthier patients, leaving other GP practices to deal with patients requiring more complex care.

GP at Hand can be used by all patients, however this type of digital service is more likely to appeal to a younger, fitter, healthier demographic and is unlikely to be used by older patients with complex needs.

This cherry-picking of healthier patients is an issue due to the way GPs are paid. GPs are paid per patient and rely on risk pooling and cross subsidy in that the fee for their younger fitter patients, who consult less often, subsidises the more expensive care for the more complex and elderly patients.

A report in November 2018 by GP Online confirmed the predictions that the GP at Hand service will attract younger, fitter patients. It found that in April 2017, 16% of patients at GP at Hand's Lillie Road surgery were aged between 20 and 29 years old, but by November 2018 this had risen to 49%.

Of the 31,519 new patients who had signed up with GP at Hand over the previous 12 months, 87% were aged between 20 and 39 years old. Patients that are over 65 now made up just 1% of the population registered with the service – compared with around 10% in April 2017.

Destabilisation of local health economy

In March 2018, Pulse reported that the success of GP at Hand was leaving the local health commissioners, Hammersmith & Fulham CCG, with a deficit. The influx of patients from across London has increased the CCG's costs significantly. Within a short space of time the CCG has around 40,000 more patients than it budgeted for. In May 2018 the CCG reported that it would need an additional £18 million in extra funding to cope with the influx of patients.

In January 2019, Hammersmith and Fulham CCG reported a deficit of £2.5 million. The CCG stated that Babylon's GP at Hand is the 'key driver' of cashflow issues. The CCG has noted that as Babylon continues to run advertising campaigns across London for new patients things are likely to get worse. The CCG has also noted that the costs associated with the Babylon GP at Hand practice could 'jeopardise' other health and care services in the area.

Deskilling of GPs

There are concerns about the effect on GP skill levels; GPs that move to work for Babylon will not face the great variety of cases seen in a normal practice. In particular, the GPs will lose skills in the area of care of the elderly and frail and in mental health.

Referral Problems

In mid-2018 it came to light that there were issues with referrals by GP at Hand for mental health services and community care outside of the Hammersmith & Fulham CCG area. GP at Hand was referring patients to services within their own CCGs, closer to where they actually lived. However, other London CCGs and providers said they were unable to accept these referrals.

After Hammersmith and Fulham CCG intervened and agreed to pay for the patients' treatment, most neighbouring CCGs and services agreed to accept referrals.

However, this now leaves Hammersmith & Fulham CCG having to pay for a large amount of out-of-area treatment. This is a major driver of the deficit that Hammersmith & Fulham CCG has accumulated (see destabilisation of the health economy).

Performance concerns

Babylon Health is very positive about the capabilities of its GP at Hand app, claiming that it has outperformed doctors and nurses. Others are not so positive.

An anonymous NHS doctor who tweets under the name @DrMurphy11 has tested the Babylon app repeatedly, highlighting problems, including when he posed as 48 year old, 40 a day male smoker who wakes "with a shoulder pain radiating down his arm" – the Babylon app told him his symptoms could be managed at home with a cold compress and painkillers, when a heart attack should have been considered.

Dr Murphy has a series of tweets known as the 'bad bot threads' that highlight the issues with the Babylon Health App.

In July 2017, an inspection of the GP at Hand service resulted in a critical report, which raised concerns about the potential for prescription misuse and lack of information sharing with a patient's primary GP.

However, the report also stated that most services "were safe, effective, caring, responsive and well-led."

Babylon Health tried to suppress the publication of this report, taking the CQC to the High Court in December 2017. The high court ruled that the report could be published; Babylon then criticised the CQC and questioned whether the regulator has the ability to regulate digital health services. In late December 2017, Babylon dropped the legal case against the CQC and agreed to pay £11,000 in legal costs.

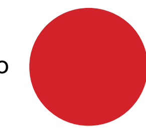
Misleading advertising

In October 2018 the Advertising Standards Authority (ASA) upheld complaints about Babylon Health's adverts on the Underground in London.

The complaints were that the ads were misleading because they did not make clear that in order to use the services advertised consumers must leave their current GP; and the GP at Hand service, including its in-person consultations, was only available to consumers who lived or worked in the catchment area of specific GP surgeries.

The complainants also challenged whether the claim "See an NHS GP in minutes" in the ads was misleading. The ASA told Babylon Health that the ads must not appear again in their current form.

By January 2019, six other complaints made to the ASA regarding Babylon Health's advertising had been resolved informally, according to the ASA website.



Other firms like HCA (right) are now moving into the market offering "private GP" services for the worried wealthy, but GP At Hand is siphoning funds from the NHS

Does the Government support Babylon Health?

Well Babylon Health certainly has a supporter in the Health and Social Care Secretary, Matt Hancock, who is himself a subscriber to GP at Hand.

Matt Hancock has, what seems to many, an inappropriately close relationship with Babylon Health. In September 2018, Mr Hancock gave a speech at Babylon's headquarters in which he told an audience of Babylon Health staff he wants to help the company expand "so loads of companies can come do what Babylon are doing" in the NHS. And in November 2018 Mr Hancock praised the company in a paid-for article in the *Evening Standard*; the Labour Party says this broke the ministerial code and has demanded an enquiry.

What is the financial background of Babylon Health?

The company has a complicated structure with several companies registered at UK Companies House. However, the operating company is a subsidiary of Jersey-based Babylon Holdings Ltd.

The ultimate controlling party is ALP Partners Ltd, a company run by Nedgroup Trust on behalf of the Parsa Family Trust. This company is based offshore.

Who has invested in Babylon Health?

Babylon is funded by private equity. It has undertaken two rounds of funding: in January 2016 Babylon raised $25 million and in April 2017, the company raised $60 million.

Lead investors include the Swedish investment group AB Kinnevik; Demis Hassabis and Mustafa Suleyman, the founders of DeepMind, the British artificial intelligence company acquired by Google; Sawiris, an Egyptian billionaire business family, NNS holdings, and Vostok New Ventures.

In February 2019, the FT reported that Babylon Health was seeking to raise $400 million for ongoing expansion.

Bed shortages hit A&E and elective care

Official figures show that despite the relatively mild winter and limited spread of flu this winter, waiting times in A&E last month were the worst since the 4-hour target to treat, admit or discharge 95% of patients was established almost 15 years ago. Only two out of 134 major A&E units hit the 4-hour target.

Overall just 84.4% of patients were seen in the target time in January: but more worryingly the situation is much worse for the most serious "type 1" A&E patients, where on average just 76.1% of patients were seen within 4 hours, and the worst-performing trust, Croydon, fell below 50% for the first time.

Emergency admissions via A&E have kept increasing, and topped 421,000 in January, up 8% on January 2018.

The delays were often driven by lack of beds and problems moving patients through the system, leaving over 13,500 ambulances delayed for over 30 minutes in handing over patients in the first week of February, 26% up on last year.

Dr Taj Hassan, President of the Royal College of Emergency Medicine told the *Independent* "The need for more beds could not be clearer."

The pressure on emergency services has had a knock-on effect on waiting times: more than 13% of patients waiting over 18 weeks for treatment in December, the worst since 2009. The 62-day target for 85% of patients to begin cancer treatment after an urgent referral was last achieved three years ago.

The Royal College of Surgeons has also blamed bed shortages and cancellations of elective operations for a drop of 70,000 in numbers of treatments in 2018 compared with 2017.

Since 2014 there has been a reduction of 200,000 elective operations carried out by the NHS in England.

Consultants expose Norfolk underfunding

John Lister

A devastating 'Demand & Capacity Review' analysing the problems facing acute and community services and primary care in Norfolk and Waveney's Sustainability and Transformation Partnership (STP) has been compiled by the Boston Consulting Group at a cost of £500,000.

It has exposed the shallowness of the STP plan drawn up in 2016. It also underlined the fundamental under-funding of local services and the need for more beds in all three acute hospital trusts, two of which are currently rated as "inadequate" by the Care Quality Commission.

The report pulls no punches, pointing out that the "fragmented commissioning landscape" (which of course was worsened by the 2012 Health and Social Care Act) is under financial pressure.

Despite rhetoric at the end of last year about Norfolk and Waveney being an "aspirant integrated care system," there are only limited plans for integration.

If things stay as they are the STP area could wind up with a £140m deficit and a shortage of 500 beds by 2023.

Moreover in moving towards any coordination and strategic planning, say the consultants, the local NHS is "starting from behind". Across the STP area there will likely be a £95m in-year deficit in 2018/19.

Indeed the largest acute trust, Norfolk & Norwich University Hospitals, which last year rejected NHS Improvement proposals for a "control total" of a £10.7m surplus and opted instead to aim for a £55m deficit, is now having to revise that figure upwards, and in January projected a deficit of £58.8m for the year.

PFI cost burden

The report states that making matters worse is the fact that the Norwich Trust is "carrying a significant PFI cost, contributing to a structural deficit".

Boston Consulting argue that "All hospitals see high volumes of non-elective work," not least as a result of "excess demand" for primary care of 9%, and a declining GP workforce, which they say contributes to higher levels of demand for emergency hospital care.

There is a severe pressure on bed numbers, with

"Non-elective demand is growing 4-8% and will fill available elective capacity within 2-3 years."

hospitals swamped with emergency admissions: "Non-elective demand is growing 4-8% and will fill available elective capacity within 2-3 years."

However there is also a problem of inadequate services outside hospital, resulting in large numbers of "Medically Fit For Discharge" (MFFD) patients occupying upwards of 160 beds in the three acute trusts.

Boston Consulting argue that if a series of interventions across the whole local NHS were successful "a total of 180 beds could be freed"

However this would require the transfer of 130 beds "or bed equivalents" into the community – and would require investment and of course workforce to deliver.

Even if all this were done, the prospect is that 120 more acute beds would be needed by 2022/23 – 85 of them in the crowded Norfolk & Norwich – and 20 more beds in Norfolk Community and Health Care trust.

Boston Consulting calls for steps to ensure the three acute trusts are enabled to collaborate together rather than compete:

"The acutes must now build from what they have already achieved, mobilise as a collective and work towards clinically led, integrated approaches to care delivery."

Although many of its proposals seem over-optimistic, and the focus excludes any discussion of mental health services other than within primary care, this consultants' report does break from the norm, by offering a brutally frank assessment of the situation, and at least attempting to take account of the full cost of the measures necessary to enable health care providers to cope.

In other areas more evasive reports are failing to get to grips with the scale of the problems.

The Lowdown will continue to follow this and similar far from integrated health systems as they assess the possibilities of moving towards "integrated care" as required by NHS England's Long Term Plan.

£6 bn bill for repairs

Backlog maintenance bills across England's NHS have now reached almost £6 billion, with more than £3 billion of this linked to "high risk" or "significant" issues, according to the latest available figures.

Six of the ten largest problems are in London – four of them in North West London (Charing Cross, St Mary's and Hammersmith Hospitals (all part of Imperial Health Care Trust, combined bill £649m) and Hillingdon (£80m).

St Helier Hospital's bill (including "moderate" risk is over £75m, and Whipps Cross Hospital (part of Barts health) has bills of £44m.

Other large bills include Doncaster with a total bill of £67m, and Nottingham University Hospitals, which faces a combined bill of £104m including a massive £77m backlog at Queen's Medical Centre. Medway Maritime Hospital in Kent has a combined bill of £58m.

The problem has grown as a result of year after year of siphoning off capital allocations to prop up revenue budgets and reduce the declared deficit.

The NHS definition of its high-risk repairs are those that "must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution".

Lack of cash brings certainty to Watford – but no new hospital for Hertfordshire

A public meeting in Hemel Hempstead on March 7 will be given the latest information on long-running plans to reconfigure hospital services in West Hertfordshire.

This comes after doubts over the future of Watford General Hospital (pictured above), and the possibility of it being replaced by a new acute hospital to be built in a more central location to cover West Hertfordshire, have been ended – by the lack of NHS capital and revenue funding.

Initial plans costing £600-£800m for the redevelopment of Watford General and St Albans City Hospital were rejected by NHS Improvement: two subsequent petitions with over 20,000 signatures between them then demanded a new acute hospital be built.

At the end of January a public meeting in Watford of over 160 people convened by the West Herts Trust and Herts Valleys CCG heard that (contrary to the CCG's subsequent misleading headline claiming that "We're closer than ever to securing funding for our hospitals") this too has now been rejected as unaffordable.

NHS Improvement has decided that the amount of capital available will be linked with the West Herts Trust's annual turnover of £350m; they have told the Trust that they won't be allowed to access private finance or phase the cost of any hospital plan.

The option of moving emergency care from Watford has been ruled out "because it would require many other interdependent services to also be relocated and would therefore cost too much."

The option of moving emergency care from Watford has been ruled out because it would cost too much.

Worse for those impatient to see investment in improved buildings and services, the CCG and Trust won't find out until the autumn spending review how much money they might be able to secure in capital funding

They have a few months to draw up a plan, but then can only hope for the best.

All three main options now centre on the West Herts trust (which has a catchment population of more than 500,000 and a target of limiting its deficit this year to £52.9m) retaining its main emergency and acute services at Watford General.

In addition to this there is the question of whether to develop Hemel Hempstead Hospital for medicine and St Albans City Hospital for surgery, or centralise all planned care at either Hemel Hempstead or St Albans hospitals – or replace both sites with a new planned care centre hospital.

Local health campaigners pointed to the poor state of repair of all three hospitals and the prospect of a substantial increase in local population putting more pressure on limited capacity.

However as might be expected the Trust's acting chief executive Helen Brown, was determined to put a positive spin on the situation, insist:

"We have a fantastic opportunity to transform services and deliver urgent and much-needed improvements to our hospital buildings."

What the (research) papers say

Flawed assumptions lead CMA to false conclusions on mergers

John Lister

NHS England's Long Term Plan, published last month ends with a plea to government to repeal or amend the law to relieve commissioners of the obligation to put services out to competitive tender, and create a legal basis for the proposed "Integrated Care Systems".

As we noted in our first pilot issue, this appears to have gone down like a lead balloon with ministers, who have not even taken the simple steps open to them to revise or scrap the regulations governing the implementation of Andrew Lansley's Health and Social Care Act.

The Act itself had to be laboriously pushed through by Tory and Liberal MPs, but the regulations, as secondary legislation, can be changed at the stroke of a ministerial pen.

One of the many unwelcome new developments brought in by the 2012 Act was to establish a role for the CMA (no, not the Country Music Awards, but the Competition and Markets Authority) in scrutinising proposed mergers of hospital trusts to ensure that they did not eliminate competition between trusts and "patient choice" in their immediate area.

Supermarkets

The CMA (formerly the Monopolies and Mergers Commission) is most used to dealing with mergers in the private sector – bus companies and supermarkets, etc.

They clearly don't understand the values or the workings of the NHS. But this level of ignorance has not stopped them taking up the cudgels – as few have seriously attempted for the past 7 or 8 years – to argue the case FOR competition between hospitals … and therefore implicitly AGAINST NHS England's current obsession with "integration" and collaboration.

> **"Our main estimate is that a hypothetical future merger between two geographically proximate hospitals would, on average and assuming no offsetting clinical benefits are unlocked by the merger, result in a 41% increase in harm rates."**

They have just published an almost impenetrable 52-page report Does Hospital Competition reduce rates of patient harm in the English NHS? It rehashes many of the lame old arguments in favour of competition, and then invents some more, with the aid of some complex mathematical formulae and densely worded arguments, using obscure language and a proliferation of baffling acronyms.

Astounding

It comes to an apparently astounding conclusion:

"Our main estimate is that a hypothetical future merger between two geographically proximate hospitals would, on average and assuming no offsetting clinical benefits are unlocked by the merger, result in a 41% increase in harm rates." (emphasis added)

Of course the use of the percentage in this statement is somewhat misleading since the overall mean "harm rate" is calculated at 1.9% of patients suffering harm (page 14). A 41% increase in this would increase the harm rate to 2.7% (i.e. 27 patients per thousand patients treated).

While any avoidable risk to patients must be minimised, many might still regard this as evidence of a relatively safe system. We have, of course no counterfactual estimate of what the harm rate might have been had existing merged hospital trusts not merged.

But if the CMA really thought the findings were as dramatic as they appear to be in this document, surely they should be right now insisting that NHS England drop its plans for integrated care, and all outstanding hospital mergers should be blocked.

Ironically many of the hospital mergers that have been taking place have done so arguing that concentration and centralisation of specialist services was essential to ensure patient safety and safe staffing levels. It will no doubt come as a shock to many trust bosses and commissioners that the CMA has formed such a negative view of the plans they propose.

Prior conviction

NHS England chair Lord Prior for example only a few days ago gave a speech to the neoliberal fundamentalists of Reform in which, according to *The Times*, he argued that "targets, competition and reliance on inspectors" had all led to "a disjointed system and demoralised staff."

Prior laid the blame at the door of "a series of NHS reforms."

These were of course carried through since 1989 by his own Tory political colleagues (and by New Labour from 1997). Now he says that that have "broken up the health service into autonomous hospitals," making it "almost impossible" to drive an integrated strategy across the NHS.

"You could not have designed something that had at its heart more dysfunction. It's truly remarkable."

Many of us who opposed these changes over the years have argued precisely this same point.

Who would have guessed that former Lehman Brothers banker and Conservative Party Chairman Prior would now reject competition (and by implication also privatisation) in the NHS, putting himself at odds with 30 years of government policy?

Now the CMA tells us that the more competition the better, and that integration is a threat to the quality of care.

There are many more questions to be asked about the assumptions made by the CMA.

Time warp

The report was published at the end of January, but appears rooted in a bizarre time warp, relying on ancient data (2013-2015) and reviving old arguments seldom heard this decade. It seems committed above all to the New Labour notion of competition as a way to offer patient choice.

Competition between rival firms failed lamentably to improve hospital cleaning

New Labour experimented with the establishment of "Independent Sector Treatment Centres" (ISTCs), which were contracted to deal only with the simplest elective cases (although initially at higher cost than NHS trusts).

Many of these contracts have subsequently ended, but the CMA appears to regard any private hospital treating NHS patients as an ISTC.

They claim, without citing any evidence, that ISTCs' "significance has grown in recent years".

In fact most of the private providers by 2016/17 not ISTCs but private hospitals. A total of 217 privately-run for profit and non-profit hospitals and clinics handled a total of just under 550,000 waiting list patients – (8.6% of the total of almost 6.4 million), and treated 431,000 out of 7.1 million day cases (6%).

The private share of elective work is no longer growing. Spending on "independent sector providers" in 2016/17 was just over £9 billion: but the following year this level of spending fell, both in cash terms and as a share of NHS spending.

Uptick

The CMA notes consolidation of trust numbers through mergers in the late 1990s, but claims "the number has since remained fairly static," although it does note an "uptick" in numbers considering merger as a result of recent financial pressure on the NHS.

Indeed mergers have continued. In 2014 according to the NAO there were 244 trusts (97 NHS trusts and 147 foundation trusts): but the latest lists show just 227. In 2016, an HSJ article reported that one in three acute hospital trusts were "set to merge, join chains or form alliances": some of these are still proceeding.

> **The report was published at the end of January, but appears rooted in a bizarre time warp, relying on ancient data and reviving old arguments seldom heard this decade**

In many areas plans are being pushed forward to downgrade services and centralise specialist services, further reducing any possibility of competition.

Capacity constraints

Yet the CMA still talks about hospitals competing to attract more patients (p7) glibly suggesting that capacity constraints, sky high levels of occupancy of available beds, and staff shortages that bedevil so many NHS trusts can easily be addressed by "reducing length of stay and managing beds more effectively, by investing or by innovating".

To confirm how out of touch they are, the CMA report adds outdated statistics – from a bygone age before the current financial pressures and bed shortages: "over 92% of patients … were seen within the 18 week referral to treatment target **between March 2012 and March 2015**." (emphasis added).

Targets missed

Today's situation is very different. The referral-to-treatment target has not been met since February 2016, and the proportion of people waiting over 18 weeks to start elective treatment reached 13.4% in December 2018 – the worst level of performance since January 2009.

Hospital trusts are in no position to compete for extra patients: they are struggling to handle the workload they have.

The CMA then throws in page after page of highly technical and statistical calculations – all based on just 2 years of data (2013/14 and 2014/15). The calculations, for what they are worth, therefore relate only to that period, rather than now.

The CMA appear blissfully unaware that since 2016, with the development of Sustainability and Transformation Plans the main debate has moved on: competition is yesterday's big idea.

Their whole approach is based on outdated theories and assumptions rather than current reality. Perhaps that's why the CMA has published the report, but not coupled it with any announcement it will ban all future mergers to avoid the claimed 41% increase in rates of harm to patients.

Tempting though it may be for some campaigners to invoke the CMA's warnings of potential harm from hospital mergers, it's best to steer well clear of this ill-conceived and deeply flawed report.

It has proved the irrelevance and ideological preoccupation of the CMA, and shown why it can never be a useful ally for those fighting for NHS values.

Dorset hits back against closures

Controversial plans for a so-called Integrated Care System in Dorset are being touted around the country by NHS bosses keen to show ICSs can improve services: last week they were quoted in a meeting of Warwick County Council by health bosses trying to win support for an ICS in Coventry and Warwickshire.

The plans seem more convincing and adequate the further people are from Dorset.

Those extolling the virtue of the Dorset plan are not so keen to mention that they involve the "centralisation" of A&E and maternity services in Bournemouth in the far east of the county, and downgrading Poole Hospital to a "cold" site delivering only elective surgery.

Dorset County Council's health scrutiny committee, unconvinced by the CCG's proposals and concerned at figures showing the potential threat to lives of emergency ambulance patients facing longer journeys from much of the county, voted last November to call on Health Secretary Matt Hancock to refer the plans to the Independent Reconfiguration Panel – the independent expert on the NHS – for full scrutiny.

The plans from Dorset CCG also involve a cutback in community hospital services, and this has triggered further protests, with 200 campaigners surrounding Portland Hospital to protest at the proposed closure of its 16 beds to move them to Weymouth.

Westhaven hospital might be just 5 miles from Portland, but it's a 45 minute journey each way by public transport, and campaigners are less than enthused by promises the building could be turned into a "health and wellbeing hub".

Who we are – and why we are launching *The Lowdown*

The Lowdown launched earlier in February 2019 with our first pilot issue and a searchable *website.*

We aim to develop in the next few months into a weekly source of evidence-based journalism and research on the NHS – something that that isn't currently available to NHS supporters.

We are seeking **your support** to help establish it as an important new resource that will help to create enduring protection for the NHS and its staff.

Our mission is to inform, explain, analyse and investigate issues and ensure that the founding principles of the NHS are upheld, in policy and practice.

Information is power, and we aim to provide people with the information tools they need to negotiate, communicate, campaign and lobby in defence of the NHS.

We will summarise news from across the media and health journals, provide critical analysis, and where necessary highlight news that might otherwise be missed, and make complex proposals understandable through a range of briefings. We will bring stories and insights you won't find anywhere else.

And we are keen to follow up YOUR stories and ideas. We welcome your input and feedback to help shape what we do.

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

They are now leading this work to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

This package is therefore something quite new, and a genuine step-up in the resources that are currently available.

As we go we will build an online archive of briefings and articles, and use the experiences and comments of NHS staff and **users to support and guide our work.**

In time we believe this will become a resource that will establish credibility with academics and journalists and which they will use to support inform and improve their own work.

The project aims to be self-sustaining, enabling it also to recruit and train new journalists, and undertake investigations and research that other organisations aren't able to take on.

By donating and backing the mission of the project, our supporters will help develop this new resource, ensuring it is freely available to campaigners and activists, get first sight of each issue, and be able to choose more personalised content.

Why is it needed?

Public support for the NHS is high: but understanding about the issues that it faces is too low, and there is too much misinformation on social media.

The mainstream news media focuses on fast-moving stories and has less time for analysis or to put health stories into context.

NHS supporters do not have a regular source of health news analysis tailored to their needs, that is professionally-produced and which can speak to a wide audience.

In our first year we will:

- establish a weekly one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally

Help us make this information available to all

We really want to run this publication without clumsy paywalls that would exclude many activists – but if we are to develop new expertise we do need to recruit staff, and so we need the resources to pay them.

We are therefore planning to fund the publication through donations from supporting organisations and individuals – and we are very grateful for those individuals and organisations who have already given or promised generous donations to enable us to start the project going.

Our business plan for the longer term includes promotion of *The Lowdown* on social media and through partner organisations, and to develop a longer-term network of supporters who pay smaller amounts each month or each year to sustain the publication as a resource.

But we still need funding up front to get under way and recruit additional journalists, so right now we are asking those who can to as much as you can afford to help us ensure we can launch it strongly and develop a wider base of support to keep it going.

We would suggest £5 per month/£50 per year for individuals, and at least £10 per month/£100 per year for organisations.

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

On the website, and in the bulletin issues from Number 1, we will gratefully acknowledge all of the founding donations that enable us to get this project off the ground.

- Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG
- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at contactus@lowdownnhs.info