THE lowdown

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

Questions for commissioners

Collapse of privatised 999 service hits NHS

One of the largest providers of 999 support in England has gone into administration, affecting a number of trusts across the country.

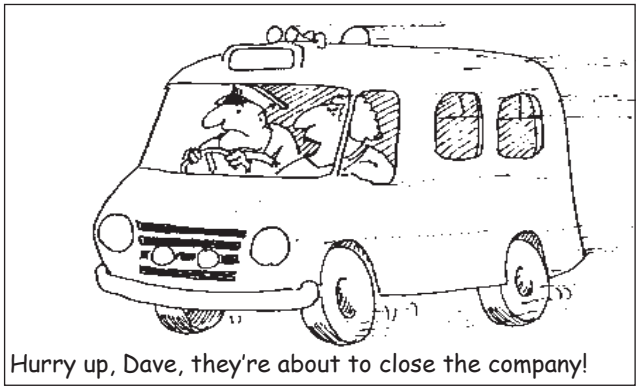
SSG UK Specialist Ambulance Support Ltd, who provided 999 emergency and non-emergency transportation for the NHS, were put into administration last week.

The company provides services for ambulance trusts all across the country including South central, East of England, North East and London.

South East Coast Ambulance Trust (SECAmb) have approached other private ambulance companies to ensure patient services are maintained, to cover the 15% of its 999 calls affected by the collapse.

The most recent company accounts for SSG UK in 2017 revealed a £250,000 net loss, but its financial position worsened over recent months, partly due to a fall in NHS work after the NHS changed its performance targets.

This story is the most recent in a catalogue of contract failures between the NHS and private ambulance companies, highlighting the insecurity associated with outsourcing these vital services.


Hurry up, Dave, they're about to close the company!

The CQC has warned against a reliance on privately run ambulance services.

Private ambulances used throughout England's NHS

At the end of August, it was revealed that the NHS England was spending upwards of £92 million in the last year on private ambulances and taxis for transporting patients. Increasingly, NHS Trusts in England are relying on private ambulances for responding to emergency calls.

Press Association research from freedom of information requests found in some parts of the South of England, 1 in 5 emergency calls were resulting in private ambulances being sent out.

The East of England Ambulance Service NHS Trust's reliance on private ambulances for emergency calls doubled in 2018/19 compared to last year, up to 26,428 call outs.

Damaging impact

In March 2019, the CQC produced a damning report that warned of patients being put at risk as a result of a reliance on privately run ambulance services. Levels of staff training varied hugely and DBS checks were not being consistently carried out.

Concerns were flagged up on staffing, safeguarding, medicine management and vehicle/equipment maintenance.

IN THIS ISSUE

Curse of PFI strikes again

The use of the 'Private Finance Initiative' (PFI) to fund new hospitals and infrastructure was a nightmare solution most famously embraced by New Labour from 2000: but the two major hospital deals signed off since the Tories took over in 2010 remain stubbornly embarrassing, costly failures.

Both the Royal Liverpool Hospital and Birmingham's Midland Metropolitan fell victim to the collapse of construction giant Carillion: work on both unfinished hospitals halted immediately, and has yet to resume. In each case the public sector is having to step in and pick up an additional £300m-plus bill for the remaining work – effectively doubling the initial cost for completing each hospital, both of which have been heavily delayed.

In Liverpool ministers have rejected calls for a full public inquiry into the scandal of a building which was not only left incomplete, but also unsafe: major sections of the work built by Carillion have had to be demolished after major structural issues were identified by the new contractors Laing O'Rourke. The trust is seeking another £300m to complete the 646-bed hospital in addition to the £76m loan to the trust to help buy out the failed PFI contract, which initially costed the new building at £335m.

In May it was revealed that the trust was having to spend £500,000 per month to look after the unused hospital, including leaving lights on 24/7 and a team running all 4,000 taps regularly to prevent bacteria building up.

Meanwhile the Sandwell and West Birmingham hospitals trust is still waiting for the go-ahead to restart building work on the Midland Met, even though a £358m contract to complete the hospital was approved by the Treasury 9 months ago.

Balance sheets propped up by huge loans

Can trusts continue as 'going concerns?'

John Lister

Mid Yorkshire Hospitals Trust's latest Annual Report (2018/19) carries a note from the Auditors warning that Mid Yorkshire Hospitals has a chronic and cumulative deficit, no plan in place to repay the accumulated deficit of £159m (almost a third of the trust's total income), no plan to return the trust to a recurrent break-even position, and relies on the expectation that "cash funding loan finance" from the Department of Health and Social Care will continue "without interruption".

On this basis the auditors note that "These events and conditions … constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern."

The auditors also report that "we are not satisfied that, in all significant respects, Mid Yorkshire Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019."

Same boat

Sounds scary: but it turns out that Mid Yorkshire is in the same boat as many other major trusts across the country: London's Royal Free Hospital has built up seven loans worth £243.9m, after posting its highest-ever deficit last year of £81m.

According to a recent Health Service Journal report so many loans have been issued to prop up flagging finances that "trusts' combined debts to the department reached £14 billion by the end of 2018-19."

Loans from the DHSC are now half as much again as the £9 billion of hospital assets still being paid for in over 100 PFI hospital projects, and set to cost a staggering £55 billion over the next 30 years, according to a new IPPR report, which echoes some of the findings of a recent book on PFI by this author.

Mid Yorkshire is one of many trusts that now demonstrate the problems of running both a loan and a PFI contract. Four of the ten trusts with the largest relative loans compared to income also have major PFI contracts.

Dozens more trusts have run up debts to the DHSC of hundreds of millions as they attempt to keep services going and deal with rising costs and demand for care after nine years of effectively frozen funding.

Four of the ten trusts with the largest relative loans compared to income also have major PFI contracts.

The most indebted as a share of trust income is Medway in Kent, with loans equivalent to almost 90% of annual turnover.

The ten most indebted trusts all owe upwards of 60% of their turnover (more than double the level in mid Yorkshire): but the largest debt is King's College Hospital in London which has run up a tab of £653m (capital loans of £139.6m and revenue / working capital loans of £514.2m) – equal to 59% of its exceptionally high trust turnover.

As the auditor implies, these loans are now on such a scale that they can never be repaid.

Last year senior NHS bosses actually floated the idea of writing them off; it's clear that with so many trusts so deep in the red and exceeding the "control total" limits, NHS England cannot intervene in them all, and the scale of cuts required to balance the books would be politically unthinkable even for a right wing Tory government.

So they settle for auditors adding largely meaningless critical notes to the accounts, to flag up the problem in a way they hope will not attract too much attention, and allow the loans to pile up – as a problem for any future government to tackle.

New campaign – by NHS bosses

Meanwhile NHS Providers, frustrated at the chronic failure of government to invest sufficient capital to maintain, let alone improve the NHS have launched a campaign of their own for additional capital funding.

A hard-hitting document headed "Rebuild Our NHS" points out three hard facts:

- No capital budget has been set for the NHS beyond 2020/21
- Current levels of capital spending are insufficient for the NHS' needs
- Existing mechanisms for individual NHS organisations to access capital funding do not work

It may not surprise many health workers to hear senior NHS managers pointing out that

"The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year), meaning issues like leaking roofs and broken boilers, ligature points

in mental health facilities and outdated technology cannot be fully addressed – even before any investment can be made in new buildings and services."

But many will be surprised to hear that

"Agreements for major new NHS infrastructure projects effectively ceased in 2015, when the PFI regime fell out of favour without an alternative being put in its place.

"In the case of some capital projects, NHS organisations have had to take out interest-bearing loans from the government to help finance them – even though almost half of all trusts reported a deficit in 2018/19 and will be unable to repay these loans."

NHS Providers go on to call for:

- A multiyear NHS capital funding settlement, "allowing the NHS to plan for the long term and transform its services and equipment"
- A commitment to bring the NHS' capital budget "into line with comparable economies".
- An efficient and effective mechanism for prioritising, accessing and spending NHS capital based on need.

Campaigners may not agree with all the schemes NHS Providers want to finance with the new money, but it's clear that the discontent with the present desperate lack of finance is not restricted to trade unions and campaigns.

Welsh bed closures have left hospitals short of capacity

Sylvia Davidson

Hospitals in Wales have the lowest number of beds available for patients since records began. The data from the Welsh Government shows that on average in 2018-19 there were only 10,564 beds available per day compared to 15,582 in 1996-97 and between 2009-10 and 2018-19, over 2,000 beds have closed.

Over this time, there has been a push to reduce hospital stays and increase treatment in the community, however when data such as A&E performance and bed occupancy rates are considered, it is clear that the bed reduction has had a negative effect on care.

Welsh hospitals have a very poor A&E performance - the percentage of patients who spend less than 4 hours in Welsh A&Es fell to 77.9% in June 2019 from 83.3% in June 2018; the target is 95% or more.

When bed occupancy is considered, Welsh government data shows that over the years bed occupancy rate has almost always increased year-on-year; from 78.3% in 1996-97 to 86.8% in 2018-19.

In 2018-19, the average available beds per day fell by 149 (1.4%) when compared with the previous 12 months, although bed occupancy improved slightly by 0.2 percentage points.

High occupancy rates are associated with increased infection risk, unsafe staffing levels and delays in treatment.

The Royal College of Emergency Medicine estimates that at least 250 more hospital beds are needed in Wales to return occupancy rates to below the safe level of 85%.

The Plaid Cymru health spokeswoman Helen Mary Jones claimed that there has been a "deliberate policy" of cutting beds with the main problem being the closure of community hospitals.

In 2013 cottage/community hospitals in Prestatyn, Blaenau Ffestiniog, Flint and Llangollen were closed. In other places wards have been closed, including in Llandudno Hospital. Bed closures have also taken place at hospitals in Swansea and Neath Port Talbot, with a reduction in general beds by the Abertawe Bro Morgannwg University (ABMU) Health Board of 79 beds out of 1,736 in 2017-18.

Further bed closures are planned at hospitals in Neath Port Talbot, Swansea and Bridgend in line with a policy to reduce time spent in hospital, reduce emergency admissions and shift care to community-based, according to the ABMU.

Totting up the cost of interest payments

One of the effects of propping up the finances of most NHS trusts using loans from the Department of Health and Social Security, which have in most cases already become impossible to repay, is that trusts wind up saddled with an additional chronic annual burden of interest payments.

In fact the weaker the finances of the trust, the harder it is for them to repay the loans that keep them going. Back in 2017 research by the HSJ showed that while for some interest rates were as low as 1%, the rate was much higher for the more indebted trusts, with rates as high as 6%.

£205m per year

Now i-news has published updates from Freedom of Information enquiries which reveal trusts are paying out over £205m a year in interest (which it equates to the salaries for 7,500 nurses), and that the rising annual bill stacks up to £607m over the past five years.

According to the *i,* nearly a third of the 184 trusts with loans have rates of 3.5 per cent or more, even though the Government is currently able to borrow money for a decade at just 0.7 per cent in annual interest.

Worse still these loans have been taken out after huge sums allocated to capital spending has been diverted into keeping day to day services running.

According to the HSJ three quarters of the money from land sales has also been diverted into revenue budgets.

South Tyneside campaigners win right to appeal

Eight months after an initial judicial review failed to rule against the downgrading of Children's A&E and Maternity by South Tyneside and Sunderland Foundation Trust, a judge has approved an appeal to be heard on either November 5th or 6th.

The judge said the "appeal is properly arguable and real prospect of success," although the fight now is to reverse cuts which have gone ahead in the meantime.

Problems accessing funding from NHS England have forced the Trust to postponed the further closures in Phase 2 of their plan until next year.

The Trust's attempts to get loans of £35m and £15m respectively from South Tyneside and Sunderland Labour Councils to help implement a scheme strongly opposed in South Tyneside have so far been blocked by the strength of the campaign.

The campaigners and legal experts have now been granted permission from the Court of Appeal to appeal the outcome of the judicial review and once again take their concerns about the closure of the hospital services to court.

Helen Smith, the specialist public lawyer at Irwin Mitchell's Newcastle office representing the Save South Tyneside Hospital Campaign Group, said: "Despite the conclusion of the judicial review, we have always remained concerned by the processes used to make this decision regarding absolutely vital hospital services.

"This is a hugely important issue which affects healthcare access for a great number of people in the region and it is clear that any decision should be taken with the utmost care.

"It is welcome that the Court of Appeal has allowed us to challenge the original decision and we are determined to once again ensure our clients' voices are heard on this matter."

Call for recognition of care staff skills as turnover levels increase

Laura Sanders

The All Party Parliamentary Group on Adult Social Care (APPG-ASC) says care workers deserve the same recognition as their NHS counterparts. This comes as their latest report reveals a staffing "black hole" in the sector.

They're now calling for social care to come under one nationalised council, which would oversee standards of pay, opportunities for professional development and employment agreements.

Staff turnover rate is double UK average

The inquiry found that a third of people working in care are leaving their jobs each year and of this, half are leaving in the first twelve months. Younger people or those with no formal care qualifications are more likely to leave.

Having a large number of vacancies in this sector directly impacts the NHS, as insufficient support to people who need care can lead to higher rates of re-admissions and bed blocking in hospitals.

In the West Midlands, there are currently 7,000 vacancies in social care (GMB regional figures). GMB Regional Organiser, David Warwick, says this is largely down to problems with staff retention.

He told Free Radio News that lack of staff had led one care home in Coventry to closing down because, as a result, the consistency in care to residents was slipping. He said,

"Fundamentally, we believe that the care sector should offer career progression for people that want to get into the sector, and it should offer them a career route which would improve recruitment and… improve retention of staff. And it would fundamentally improve the care for the people in the homes that need looking after."

"A demoralised, low paid workforce"

Inquiry evidence from the charity Independent Age revealed that for 20 years' experience, a care worker could expect an extra 15p per hour than someone with 12 months' experience (March 2018 figures).

At the same time, it's estimated that 500,000 care workers across the UK are being paid below the Real Living Wage (£8.21 as of March 2019).

The average wage for a social care worker is £7.89 an hour, (Skills For Care NLW 2018 statistics). In the West Midlands, the average is £7.71.

David Warwick added: "The GMB policy on the care sector is that the starting wage should be the real living wage, that there should be quality care training in place done at work, and that the ratios of staff to residents is brought up to an agreed level of safe care."

One of the advisory bodies to the APPG-ASC report, forecasts a need for an extra 580,000 social care workers by 2030 if it is to keep up with the number of people age 65 or over.

Rising demands

At the same time, Skills For Care, one of the advisory bodies to the APPG-ASC report, forecasts a need for an extra 580,000 social care workers by 2030 if it is to keep up with the number of people age 65 or over.

Workforce structure

The adult social care workforce is worth an estimated £46.2 billion, and is in fact larger than the NHS.

Whilst a proportion of social care workers are under the NHS, most are employed by one of the 21,000 organisations in the independent sector.

The report from the APPG-ASC argues that having a national body for social care providers would help to regulate pay, training and employment agreements.

Achieving parity with the NHS

Proposals for a national care Council to be introduced focus on clear pathways for professional development, and a national guideline for agreeing pay and employment in the care sector.

For care workers, this would mean greater opportunities to progress with the introduction of a compulsory accredited care certificate. In addition, a qualification package and a registration period would be introduced, and professional development would be recognised with pay.

The APPG-ASC wants this new council to be affiliated with the NHS and says it will be first step towards care workers achieving the parity of their NHS counterparts

■ The full APPG-ASC report can be found here.

Asked to make a cut too far, NHS trust chief exec resigns

After two years at the helm of South Tees Hospitals Foundation Trust, Siobhan McArdle, announced her resignation in a letter to staff.

The letter, seen by the Health Service Journal, noted that the personal cost of being an NHS CEO was too high and that the demands for cost-savings were "too great a challenge."

The letter also notes that McArdle's resignation was influenced by the "very challenging" nature of the regulatory and financial environment and that the South Tees local health economy is "underfunded and unsustainable."

South Tees is saddled with huge debts from two Private Finance Initiatives (PFI) and long-term underfunding, and McArdle notes that the trust is unsustainable without a long-term funding plan and capital investment. Something which she said her team had been fighting for continually over the past four years.

The trust has two PFI contracts - the James Cook University Hospital and Redcar Primary Care Hospital - which have 15 and 21 years, respectively, left to run and about £1 billion left to pay by 2040.

In total, the James Cook in Middlesbrough will have cost South Tees Hospitals NHS Foundation Trust £1.5 billion to build and run since it opened in 2003, with a final payment in 2034.

In 2018, the trust paid a charge of £50 million for the James Cook and £4.1 million for the Redcar hospital: each year these charges increase.

McArdle is not alone in facing a seemingly impossible challenge as a CEO of an NHS trust. Saffron Cordery, of NHS Providers, which represents trusts, said: "The concerns expressed here are not unusual. In recent years trust leaders have become accustomed to demands for productivity improvements and savings that are increasingly unachievable."

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In 2019, there were 127 PFI schemes in England for hospitals and social care. A September 2019 report from the IPPR thinktank, The Make Do and Mend Health Service, noted that hospital trusts will still have to make £55 billion in payments for PFI contracts by the time the last contract ends in 2050. An initial £13 billion in private investment will end up costing the NHS £80 billion.

A few Trusts have succeeded in escaping from these contracts, including South Tees' neighbour, the Tees, Esk and Wear Valley Trust which runs Middlesbrough's Roseberry Park mental health hospital.

In 2018, the trust won High Court battle to get out of its PFI deal.

The win hinged on the finding of numerous problems with the seven-year-old building, which resulted in patients being forced to move out. The full cost to the trust if that deal ran to its end in 2039/40 would have been £323.5 million.

As well as the huge PFI debt, South Tees NHS FT, along with the rest of the NHS has been struggling for years under a regime of underfunding.

The funding announcement in the Autumn budget in 2018 of £20.5 billion over five years, was very quickly shown to be insufficient.

The 3.4% rise in spending is significantly lower than the 4.3% annual growth in the Office for Budget Responsibility's projection of future cost pressures. This is an estimate that the IFS, think tanks and most economists agree is a fair measure of how much money the NHS needs just to keep up with demand, let alone improve standards.

The vast majority of hospital trusts, including South Tees, will also not benefit from the most recent announcement of money in August 2019.

This time an extra £1.8 billion in funding was promised but this was also very quickly shown to be all smoke and mirrors.

The vast majority of the money was not new at all, but money that had been promised to those NHS trusts by the Department of Health and Social Care (DHSC) after they cut their spending significantly.

However the promised reward for the spending cuts was not given to the trusts by the DHSC. The 'new' money is primarily a release of this 'reward' money and will only be given to 20 projects; South Tees NHS FT is not one of these projects.

Faltering promises to support cancer care are costing lives

PAUL EVANS

Now that half of us will get cancer at some point in our lives why can't we all have the best chance of beating it? Figures from Cancer Research UK this week illuminate how government inaction on NHS staffing is denying patients early access to diagnosis and treatment.

Every year around 115,000 cancer patients in England are diagnosed too late to have the best chance at survival, according to a fresh analysis from the cancer charity.

All the evidence points to the fact that catching cancer early provides a much better chance of successful treatment, but Cancer Research UK believe a lack of capacity is the biggest impediment.

Criticising the government's progress in increasing the NHS workforce in critical areas like diagnosis they highlighted that 1 in 10 of these posts are currently unfilled.

"There's no plan to increase the number of NHS staff to cope with demand now or the growing numbers in the future" says Emma Greenwood, Cancer Research UK's director of policy.

Bold promises

Last year the government pledged to catch 75% of stage 1 and 11 cancers by 2028.

That would mean a big step up in activity – with an extra 100,000 patients diagnosed early each year, but how realistic is this when currently cancer services are struggling to tread water.

Hospitals are continuing to miss their targets to start treatment quickly according to the latest NHS data for cancer waiting times. The current commitment is a maximum wait of 62 days from the time of referral by a GP, in fact nearly a quarter of patients wait longer

A dossier of evidence collected by the Hospital Consultants and Specialists Association (HCSA) confirms the problems with understaffing. A consultant radiologist reported that "Scan report turnaround time has gone from one week to over a month. Unexpected and critical findings are going unreported for weeks. We are now just firefighting."

The HCSA report that delays of five to six weeks for scans are common and patients are turning up to outpatient appointments but leaving without their results because scans are not available.

Despite a shortage of over 100,000 staff across the NHS and dire warnings that this is projected to rise to 250,000 by 2030 without the proper action, the government response has been painfully slow.

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Only last year as the NHS celebrated its 70th birthday ministers pledged to catch 75% of stage 1 and 11 cancers by 2028

Missing plans

NHS England omitted any substantial workforce strategy from its 10-year plan for the NHS, launched in January.

When the plan finally arrived, it was an interim plan, widely welcomed for its intentions and analysis, but stymied by a lack of the essential funding that NHS leaders need to press on with training and recruitment.

Crucial treasury spending decisions were due this Autumn but have once again been delayed, probably until next year. The government is mired in political crisis and have lost all impetus on this crucial element in the NHS recovery. Meanwhile services are crying out for decisive support. NHS leaders, eyeing up another tough winter are left to struggle with growing demand, a flagging workforce and compromised services.

Just this week a BMA survey warned that nine in 10 doctors fear a 'toxic combination' of rising workload and understaffing will force them into making mistakes. The unified call being made from across the service is "give us more staff!"

The Government was told about severe staff shortages in NHS cancer care back In July 2015, according to the chair of the Independent Cancer Taskforce, Sir Harpal Kumar,

"It's totally unacceptable that these shortages could now lead to delays in patients getting treatment."

The Government defence is that they have already committed an extra £20.5 billion to the NHS over five years, but economists – including their own, have concluded that this investment is not enough to expand capacity and does not include the funding to train and hire new staff.

The Chancellor, Sajid Javid announced that the government will invest £250 million on new artificial intelligence technologies to help relieve the workload of doctors and nurses, but health experts remind us that

new technology would need time to become proven and this that would not fill the gaping hole in the workforce.

Capacity shortfall

Right now, staff shortages are affecting every part of cancer care according to work commissioned by Cancer Research UK. It is estimated that by 2027, the NHS needs:

- An additional 1,700 radiologists – people who report on imaging scans – increasing the total number to nearly 4,800
- To nearly triple its number of oncologists – doctors specialising in treating patients with cancer – a jump from 1,155 to 3,000
- Nearly 2,000 additional therapeutic radiographers – people who give radiotherapy to cancer patients – increasing the total to almost 4,800

The staffing crisis is double edged. There is not enough money to train the specialists of the future, but also many existing posts cannot be filled.

The Royal College of Radiologists says that one in six UK cancer centres now operates with fewer clinical oncology consultants than five years ago.

Vacancies for clinical oncology posts are now double what they were in 2013 – with more than half of vacant posts empty for a year or more.

Good and bad

Despite all the pressures, important progress has been made with improving services over the last 20 years. Cancer networks have adopted and shared the most effective techniques and survival rates have risen across many of the common cancers.

One in six UK cancer centres now operates with fewer clinical oncology consultants than five years ago. Vacancies for clinical oncology posts are now double what they were in 2013

However, the UK lags still behind other countries, performing worse than Australia, Canada, Denmark, Ireland, New Zealand and Norway, a study in Lancet Oncology found. Although based on data between 1995-2014 it backs up that case that the NHS needs a step-change in early treatment to catch up.

Sara Hyam who helped launch Cancer Research's campaign for more staff is confident that the problem does not lie in clinical approaches and believes the NHS has doctors and its treatments can match the best available anywhere in the world. The primary issue is that we are not treating patients early enough to give them the best chance at full recovery.

Shortages of staff are not the only factor: patients can be reluctant to acknowledge their symptoms and visit GP and in the past GPs have not always picked up on warning signs, but both of these factors are showing signs of improvement.

Broken promises cost lives

Healthcare is complex, but the keystone to building a service that can meet our needs is a resolute plan to put trained staff in the right posts to raise capacity.

Our government have been given this message loud and clear. Staff surveys, academic studies and the emotional experience of patients all echo the same themes.

Faith in politicians is at its lowest, but on the NHS and cancer specifically, they have lain out a string of powerful promises and asked to be judged on them.

With an election shortly upon us we will no doubt have to listen to more earnest pledges, but further inaction in the face of these basic health needs should rightly be regarded as a crime of neglect.

CCG mergers: efficiency drive, or something more sinister?

The NHS is caught up in more top down change. In over 20 areas the local bodies responsible for paying and organising our healthcare - Clinical Commissioning Groups (CCGs) are involved in a series of mergers, to form entities that cover much wider areas. The reasons behind the change are already causing controversy, not least because the public are in many cases being kept out of the process.

The two drivers of the CCG mergers are financial and the development of integrated care systems (ICS). They amount to a major NHS re-structure just a few years after its biggest shake-up to date in 2012.

In November 2018, NHS England wrote to all CCGs telling them they needed to make 20% efficiency savings to their running costs, placing "administration limits" on each.

NHS England have suggested that they save money by "exploring mergers and joint ways of working" - share back office and other functions and aim for savings on administration and a greater spend on patient care.

Casting doubt on the plan an HSJ analysis concluded that efficiency savings from mergers will not deliver the 20% reduction in running costs and in many situations may result in extra cuts.

Nationwide CCG mergers are designed to enable the government's new direction for the NHS – which is based around the development of Integrated Care Systems across England, as outlined in the NHS long-term plan announced in January 2019.

The plan states that England should be covered by ICSs by April 2021, and that an ICS should have just one CCG acting as commissioner across its area.

To speed up the merger process NHS England will now approve mergers throughout the year rather than just once a year.

The largest new CCG being planned will be formed by the merger of eight CCGs in North West London; this will cover 2.2 million people.

Political expediency plays a strong part in the merger plan as the government does not have a majority to get a new NHS reorganisation bill through Parliament.

Therefore, merging CCGs to the size of the bigger integrated Care Systems is a work-around solution to form a new structure out of the existing CCGs – who despite the emergence of ISCs will remain the body with the statutory responsibility for planning and funding local healthcare.

The Public Accounts Committee states: "We are … concerned about how patients will understand who makes decisions and keeps a close eye on the local NHS finances."

Why is it controversial?

Some commentators see this as u-turn away from the idea of local decision-making that was a strong theme within the 2012 NHS changes. They claim that forming super-CCGs will make health planning more remote from the populations they serve.

Local GPs who were cast as being in the driving seat of CCGs back in 2012 are now feeling distinctly left out, according to a Dr Richard Vautrey, chair of the BMA's GP committee.

"We have heard from members who are extremely alarmed that mergers appear to be rapidly moving forward in their areas without clear approval from, or sufficient engagement with, local GPs," he said.

Threat to planning

In early 2019, the Public Accounts Committee (PAC), commenting on the move to commissioning of services by ICS across much larger areas, noted:

"There is a risk that CCGs will lose touch with the needs of their local populations as they commission services across larger populations. It is vital that CCGs, in whatever form, understand the needs of their local populations and have good links with local GPs. But as CCGs become responsible for commissioning services across larger populations there will be a tension between commissioning at a larger scale while maintaining an understanding of the health needs of local populations."

A November 2018 report from the National Audit Office on CCGs also noted that the mergers seem to go against one of the original aims of the CCGs, that of commissioning services appropriate to the needs of patients in the local area:

"This larger scale is intended to help with planning, integrating services and consolidating CCGs' leadership capability. However, there is a risk that commissioning across a larger population will make it more difficult for CCGs to design local health services that are responsive to patients' needs, one of the original objectives of CCGs."

Accountability

The Public Accounts Committee has also identified a loss of accountability for patients:

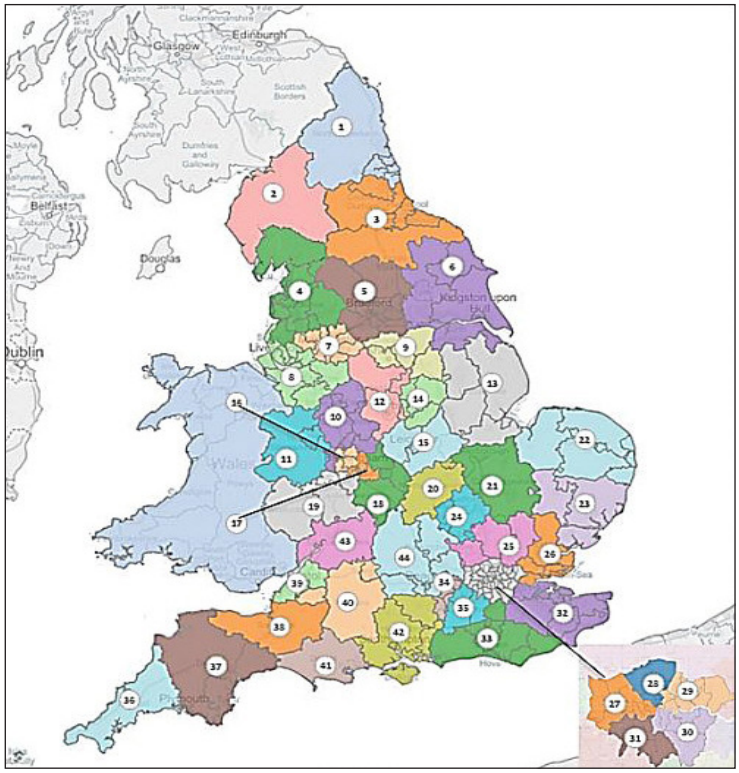
"We are also concerned about how patients will understand who makes decisions and keeps a close

Enforcing "tricky" decisions

One of the reasons behind mergers is to minimise any local voice or dissent while controversial closures and downgrades of hospitals and services are pushed through.

In Lancashire and South Cumbria, where 8 CCGs are planning a giant merger alongside the formation of an "integrated care system", the director of finance and investment has openly stated to the Health Service Journal that: "The place we need to get to is where we can enforce decisions on a majority basis." He wants to be able to push through "tricky" decisions that will be opposed locally.

Hospital "reconfiguration" is a key concern in Lancashire, with potential permanent loss of A&E and acute services in Chorley: eliminating any local voice will make that easier.



Top-down changes in 2016 carved England's NHS into 44 Sustainability & Transformation Plans. If CCG mergers continue to spread, the current 191 CCGs could be merged into as few as 40 by 2021.

eye on the local NHS finances."

At present the performance of individual CCGs is assessed by NHS England; PAC was concerned that as the ICS develop, accountability systems will be weakened as NHS England moves to assessing entire ICS rather than individual CCGs.

"it is important not to lose sight of the need for robust accountability structures which make it clear who is ultimately responsible for planning and commissioning decisions."

Existing flaws made worse

The accountability of commissioning and other key decisions has already come under sharp criticism and critics believe that these weaknesses will be exacerbated through mergers.

A catalogue of contracts have collapsed after CCG led tendering processes and local critics have called for these decisions to be more accountable and transparent.

Public consultations over aspects of local healthcare have been criticised for not offering meaningful involvement or for being side-stepped altogether. CCG decisions, especially around reconfigurations have often ended up facing local campaigns and have ended up being examined in the courts on multiple occasions.

Undermine the NHS

Other critics take the view that integrated care contracts will break down the central principle of the NHS to provide healthcare to all in our community.

The contracts may exclude or limit access to some healthcare and suggest a drift towards some of the characteristics of US-style accountable care.

After pressure from campaigners ministers have ruled out the possibility that private companies would be allowed to run an entire integrated care system under contract, but there is continuing concern about their influence and control.

In Thurrock, the local council criticised NHS England's "dreadful" proposals to merge the five CCGs in south and mid-Essex

A briefing by Keep Our NHS Public raises concerns about how Accountable Care Organisations will cement the decay of public funding of the NHS and help to strip NHS assets, such as land and buildings.

Public campaigns

Campaign groups across the country, such as South Warwickshire Keep our NHS Public and Save Southend NHS , are concerned that the merger decisions have been made to save money alone and will lead to services not being targeted at a local level.

The groups have also criticised a lack of consultation and about a future lack of transparency.

In Thurrock, the local council criticised NHS England's "dreadful" proposals to merge the five clinical commissioning groups (CCGs) in south and mid-Essex. Thurrock Council fears the loss of local accountability and strong existing partnerships and that a more centralised approach, could mean the different needs of patients and local priorities in the five areas would not be fully taken into account.

There are also concerns that GPs already do not have sufficient input into CCG decisions, and this will only get worse as the size of the CCG increases.

The Public Accounts Committee heard that a study by the King's Fund and the Nuffield Trust found only 28% of GP practices feel they can influence the decisions of CCGs.

Have local people been consulted on the proposals?

The mergers cannot take place without approval from the members of the CCGs.

There is some confusion, however, over how much consultation with the public is needed.

In many areas consultations have not taken place, but areas that have consulted include Birmingham and Solihull, Wyre Forest, Bradford and District, and Nottinghamshire/Nottingham. The public consultation in Birmingham for a merger that took place in 2018 was criticised by HealthWatch Solihull, as people felt they "did not have all the facts to allow them to make an informed decision."

As reported in the Lowdown last week Lewisham Hospital campaigners are demanding that there be full public consultation on CCG merger plans – and they believe they have the law on their side.

The campaigners have gone back to the amended NHS Act 2006 which (14G) stipulates that CCG mergers involve both the dissolution of the pre-existing CCGs and the formation of a new CCG.

And they have found that according to the Regulations governing the implementation of the Act, dissolution of a CCG requires the CCG to seek the views of all the people in the CCG area.

What are Integrated Care Systems?

Integrated care is an attempt get organisations working together to meet the health needs of their local population.

Integrated Care Systems are part of new policy to redesign the NHS through the creation of a partnership of organisations to plan and deliver care; involving NHS providers, commissioners, local authorities, third sector and for-profit companies.

In some areas ICSs will develop a single contract and one organisation will be take the lead and be responsible for its delivery under a fixed budget and by subcontracting the delivery of care to range of NHS, charity and private providers.

Campaigners have objected to the new scope for privatisation, and the lack of public accountability of ICSs which have no legal standing under the current NHS legislation.

No Deal Brexit: How bad can it be?

Hannah Flynn

The level of disruption that could be caused for the NHS by a no-deal Brexit was thrown into the spotlight last month when details from the Government's Operation Yellowhammer were leaked.

The Government has now been forced to publish the documents in full by Parliament, and the Scottish Parliament has already published its own no deal briefing highlighting healthcare as one of 12 most at risk areas. Most worryingly, the now officially published documents confirm the risk of medicines shortages, along with at least three months of shortages of food and fuel as border crossing points struggle to deal with checks. Operation Yellowhammer also assumes the eventual return of a hard border between the Republic and Northern Ireland.

Despite losing his majority and control of Parliament, Prime Minister Boris Johnson has continued to repeat his pledge that the UK will leave the European Union on 31 October 2019, whether a deal has been agreed with the EU or not. So what challenges will the NHS have to deal with in the face of a no deal Brexit?

Medicines supply shortages

A recent media storm surrounded an on-air argument between Jacob Rees-Mogg MP and Dr David Nicholl, who had advised the Government on the risks of leaving the EU without a deal on patients and their medicine supply.

Rees-Mogg suggested Nicholl was irresponsible for vocalising "the worst excess of Project Fear", despite leaked Operation Yellowhammer documents warning delays at channel crossings would make medicines "particularly vulnerable to severe extended delays" "with significant disruption lasting up to six months" if unmitigated. These could impact as much as 40-60 per cent of imports from day one.

Medicines and medical supplies that required specific transport conditions, such as temperature controlled environments like insulin, or had short shelf-lives such as medical radio isotopes, would be particularly hard-hit, the documents warned. Heads of health bodies including the RCN, RCM and BMA warned at the end of August that agents necessary for cancer diagnosis and treatment were at risk in a no-deal scenario.

It is unclear what the impact of tariffs would be on exports, and it is hoped the World Trade Organisation (WTO) would agree to a WTO Pharmaceutical Tariff Elimination Agreement in the case of the UK leaving the EU without a deal. The cost of any tariffs would almost entirely be borne by the NHS.

The pro Leave Institute of Economic Affairs (IEA) believe that tariffs would affect a limited number of pharma ingredients and devices but acknowledge that the NHS would have to absorb a rise in prices on some products.

Royal Pharmaceutical Society Director of Pharmacy and Member Experience Robbie Turner said it was important to remember that global supply chain issues for medicines had been an issue for years, and "we will continue to see shortages for years to come and no deal Brexit could make that worse, but we have no indication that the global supply chain issues will be altered by Brexit."

45 per cent of doctors from the EU stated they were considering leaving the country and one fifth had made plans to leave.

Staff shortages

There are already 100,000 vacancies in the NHS, a situation that is set to worsen in or out of the EU due to increased demands on our health services. The Kings Fund has calculated that the UK needs to recruit at least 5,000 new nurses each year from abroad to simply stop the situation worsening.

There are 116,000 EU nationals working in health care, meaning that any impact on them has the potential to significantly impact the health service, a joint letter by The Kings Fund, the Health Foundation and Nuffield Trust has warned. A BMA survey found that 45 per cent of doctors from the EU stated they were considering leaving the country and one fifth had made plans to leave.

If a no deal Brexit caused a significant drop in the pound, then many NHS staff could leave if it makes working in the UK no longer a competitive option, The Kings Fund has also warned.

The reintroduction of a hard border between Northern Ireland and the Republic of Ireland could also cause a disproportionate impact locally due to a high vacancy rate in Northern Ireland, as NHS staff who reside in the Republic could struggle to get into work.

This would be exacerbated by Home Secretary Priti Patel's plans to remove freedom of movement for EU nationals on 31 October.

Economy

The Budget for Office Responsibility has claimed that a no deal scenario would likely require an extra £30 billion of borrowing each year.

This is more money than was spent on adult social care and investment in NHS buildings and equipment in 2017/18 alone according to The Kings Fund.

Economically problematic is also the precarious nature of many of the companies that are now responsible for outsourced health and social care. Operation Yellowhammer documents warned:

"An increase in inflation after the UK's EU exit would affect providers of adult social care through increasing staff and supply costs, with smaller providers impacted within 2-3 months and larger providers 4-6 months after exit."

Guy Collis, a Policy Officer at UNISON explains how this might have an impact on the NHS:

"So many companies in social care are already in a very unstable financial position, and if there is the expected shock on the wider economy then numbers of providers could be exiting the sector or going bankrupt, and the likelihood is then there will be a fairly major knock on impact on the NHS."

"Though it is unclear what emergency support the NHS would be expected to provide, care homes going bust could see an increase in demand on A&E and community services which are already under significant pressure.

"Even if there was no Brexit whatsoever we would still see a number of care providers going under like Southern Cross a few years back.

"The problem is the services and staff usually transfer to another operator, but if they are all experiencing problems [following a no deal Brexit] then it is not clear how easy that would be," Collis warns.

The impact of leaving the EU without a deal on fuel and food availability could also affect the NHS practically and financially.

Rising costs and shortages

Looking outside of the health and social care system, it is also likely that the impact of leaving the EU without a deal on fuel and food availability could also affect the NHS practically and financially.

Even if "everyone will have the food they need" as promised by Michael Gove, increases in the cost of food and fuel could further squeeze NHS budgets. If the UK leaves the EU with no deal then it will be subject to World Trade Organisation tariffs on food and other products, such as a 35 per cent tariff on dairy. Skyrocketing hospital food bills aren't going to help anyone.

Speaking at an Exiting the EU Select Committee hearing, Andrew Opie the British Retail Consortium director of food and sustainability said: "I think there's been too little debate around the three, six, nine-month period [after Brexit],"

"For us, for example, we will [initially] have a temporary tariff on food, but how long will that temporary tariff last?", reported Civil Service World. He also warned that late October would be the worst possible time for the UK to face a no deal Brexit as its fresh food import needs peak over the winter.

Dave Prentis warned ahead of the Trades Union Congress in Brighton this week that: "the catalogue of logistical nightmares goes on. The NHS serves more than 140 million meals to patients every year, with much of the food imported from Europe.

"Possible fuel shortages could have a severe impact on 6,500 emergency ambulances and their crews operating countrywide, especially those in areas with lorries queuing out of the ports."

While it is not expected that the World Trade Organisation would implement tariffs for gas and electricity in the case of a no deal Brexit, industry experts do expect costs to rise, Bloomberg reported earlier this year.

NHS chronic underfunding has left it with a £991 million combined deficit according to the National Audit Office, making it unclear where any money will come from to pay for these rising costs of running NHS services.

While it would be incorrect to blame all of the NHS's problems on a no deal Brexit, it is certainly the case that leaving the EU without a deal will significantly exacerbate a wide range of problems already afflicting our underfunded services.

THE lowdown

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.*

Since then we have published every 2 weeks as a 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 regular 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 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