THE lowdown

Health news, analysis and campaigns.
NUMBER 18, February 14 2020

Informing, alerting and empowering NHS staff and campaigners

Inquiry into chronic system failures at East Kent Trust

Family handout

Harry Richford with his parents: his death was avoidable.

With a major investigation still continuing in Shropshire, examining hundreds of potential failures of maternity care, yet another hospital Trust is under investigation for chronic failures in maternity care, resulting in loss of life. And as so often seems to be the case poor quality care and a toxic management culture have been linked with low levels of investment, staff shortages, poor morale and bullying.

It took a prolonged campaign by the family of baby Harry Richford, who died at Queen Mary the Queen Mother Hospital in 2017, to even secure a proper inquest.

And it's the findings of that 3-week inquest that his death was "wholly avoidable" that have finally forced ministers to call an independent inquiry into the chronic failure of health care and management at the East Kent Hospitals Trust's maternity department.

According to the BBC, 26 maternity cases at the Trust going back to 2011 are already being investigated by the Healthcare Safety Investigation Branch, amid fears of at least seven preventable baby deaths since 2016.

Morecambe Bay

The new inquiry is to be headed by Dr Bill Kirkup, who chaired the 2015 inquiry into maternity service failures at Morecambe Bay, and who was one of the witnesses criticising the East Kent Trust at the inquest. Key lessons of that inquiry have plainly not been learned in East Kent.

Chief Executive Susan Acott, who had consistently tried to minimise the scale of the problem, despite a coroner's ruling last month that Harry Richford's death resulted from neglect in the maternity unit of East Kent Hospitals NHS Trust, was accused of being "in denial" by Harry's grandfather Derek Richford.

Repeated early warnings of problems had been ignored, including a damning report by the Royal College of Obstetricians and Gynaecologists back in 2015

He had had to battle for six months even to get the Trust to report Harry's death to the Coroner, and told BBC Radio 4's Today Programme that a so-called "root cause analysis" report by the Trust, signed off by the Medical Director, had concluded there was no need for the Coroner to be called in.

No resignations

In the event the coroner identified SEVEN serious failings by the Trust. Expert reports commissioned by the Coroner on midwifery, obstetrics and paediatrics all found multiple failures, pointing the finger not just at the professional staff but also at the system of care and the Trust's senior management, who have refused to resign, despite being urged to do so at the Board meeting by public governor Alex Lister.

Worse still there repeated early warnings of problems had been ignored, including a damning report by the Royal College of Obstetricians and Gynaecologists back in 2015, which revealed that senior medical staff frequently failed to turn up for evening and weekend shifts at the Margate Hospital, and junior staff had seen little point in reporting this or other safety concerns because management had done nothing in response to previous reports.

Junior staff were fearful of harassment and intimidation, and noted that even where safety errors were reported no action was taken by the trust.

Nor have the Care Quality Commission come well out of this: in 2016 and 2018 their inspections rated the Trust "requires improvement" on four of the five standard criteria, but there has apparently been no further follow up and the CQC seems not to have seen or received the RCOG report until January last year.

● **Kent & Medway STP seeking £820m capital – p2**

IN THIS ISSUE

Kent and Medway seeking £820m for capital projects

John Lister

Enormous gaps in staffing, availability of capital and revenue funding seem set to stymie long term plans set out in the Kent and Medway 'Strategy Delivery Plan' published this month in board papers for the troubled East Kent Hospitals FT.

Since the Trust has not even made it onto the "long list" of 21 given seed funding to plan for new hospitals in five years' time, it is astounding that the plan admits to including a "suite of projects" ("ranging from £500,000 to £363 million") requiring a total of £821 million (p72).

The HSJ now reports that these figures include huge increased estimates for the cost of rebuilding the William Harvey Hospital in Ashford – from £160m in November 2017 to £351m now. The projected cost of an alternative scheme for a new hospital in Canterbury (which seemed to have won support from Boris Johnson in an unguarded remark at last year's Conservative conference, later denied) has risen from £250m to £363m.

Back in 2016 most of the 44 Sustainability and Transformation Plans were characterised by huge and unrealistic requirements for capital investment, totalling £14.3 billion, when it was widely recognised that nothing like that amount would be available.

Now Kent and Medway, which then included no capital requirement in their STP, have set out their demands, which if replicated in all 42 areas responding to the Long Term Plan could stack up to well over £34 billion.

However there are other worrying aspects of the K&M plan.

It admits (p75) to dire workforce shortages in primary care (among the most severe in the country, with 25% of GPs and 55% of general practice nurses approaching possible retirement) in mental health (with a required total growth in the mental health practitioner workforce of 1577 FTE by 2024 – an increase of 50%, including including psychiatrists and nurses).

● **The full length version of this abridged article can be found online at *https://lowdownnhs.info.***

The new hospital is just one element of Kent & Medway's mid/long term plan

The submission to NHS England lists investment adding up to a hefty £637m:

- Stroke services Reconfiguration - **£27.7m**
- East Kent Acute Redesign - Option 1 = **£351m**, Option 2 =**£363m**
- Acute bids - **£224m** (excluding the EK Redesign)
- Local Care including primary care **£211m**
- Mental Health - **£31m**

Health problems dog "red wall" areas

There are major health problems in the majority of the 48 parliamentary seats won from Labour by the Tories in December's general election. Figures from the Health Foundation think tank show that average female healthy life expectancy in the new Tory seats is just 60.9 years.

This is lower than the healthy life expectancy in the areas Labour held (61.4), below the England average of 63.9 years, and over four years less than the 65 years of life expectancy in wealthier traditional Tory seats.

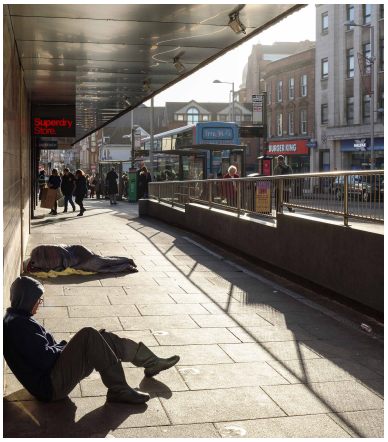
The Health Foundation expresses the hope that the new cohort of northern and midlands Tory MPs will see this as "an incentive to take action on improving healthy life expectancy".

However for many older people it's already too late. The Health Foundation also points out that the strongest influences on health are "the circumstances in which we are born, grow, live, work and age," known as social determinants of health.

Poorest areas

The reality is that the newly-elected Tories now represent some of the poorest parts of the country, while the core of their party is based in the wealthiest: and only policies that seek to redistribute some if that wealth away from the richest can improve the living standards and living conditions of those on the lowest incomes.

Geographer Danny Dorling points out that after a decade of austerity and massive cuts in local government and welfare spending, life expectancy across the whole of the UK has begun to fall, for the first time in recent history: we are the only country in Europe where this is happening.



Tory ministers and Public Health England have tried to blame the weather and the flu – but the UK has not had an exceptionally cold winter since 2010, and there has not been a major flu epidemic.

Dorling points out that premature deaths of older people have risen as social care has been cut back, leaving a million without support, and real terms NHS funding has fallen.

But infant mortality has also been rising in England and Wales, but falling in Scotland, where the government has diverted funds to invest in mothers and babies.

NHS policies claim to be reducing inequalities in health, but there is growing concern that welfare and social care spending cuts are causing inequalities to widen, and a new report from the Nuffield Trust points out that this also applies to health care, resulting in a "double deficit", where people in these areas have greater needs but also poorer access to GP services and hospital care.

With a staggering £100 billion (and more) now being thrown at the dubious HS2 project to speed the journeys of wealthy people travelling north (and back again), many of those who voted Tory for the first time would benefit far more from dropping the planned new round of spending cuts, and instead spending even a fraction of the HS2 budget to improve health and social care and revive the flagging economy of what is becoming the 'northern poorhouse'.

Thank you – but we still need more support

A huge thank you to the supporter who has kindly donated a magnificent £5,000 towards this year's appeal to keep *The Lowdown* running without a pay wall and free to access for campaigners and union activists.

We have therefore always planned to fund the publication through donations from supporting organisations and individuals.

Having managed to raise enough money for our first year we now urgently need more to keep going.

We urge union branches to send us a donation … but also please propose to your regional and national committees that they invite one of our editors to speak about the project and appeal for wider support.

We know many readers are willing to make a contribution, but have not yet done so.

We are now asking those who can to give as much as you can afford.

We suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can give us more, please do.

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

● **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*

In our first year, as promised, we:

- established a regular one-stop summary of key health and social care news and policy
- produced articles highlighting the strengths of the NHS as a model and its achievements
- maintained a consistent, evidence-based critique of all forms of privatisation
- published analysis of health policies and strategies, including the NHS Long Term Plan
- written explainer articles to promote wider understanding
- created a website that gives free access to the main content for all those wanting the facts
- pursued special investigations into key issues of concern, including those flagged up by supporters
- connected our content with campaigns and action, both locally and nationally.

To go into a second year we need YOUR HELP

The Lowdown launched in February 2019 with our first pilot issue and a searchable website. Our initial funding came from substantial donations from trade unions and a generous individual.

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – **something that was not previously available to NHS supporters.**

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.

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

The aim of the project has been to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

To get it under way, we have worked hard to get the name established, build a core readership, and raise money where we can.

We need to make the project self-sustaining, so we can pay new journalists to specialise, and undertake investigations and research that other organisations aren't able to take on.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https://lowdownnhs.info/ contactus@lowdownnhs.info

We have had some success, and thank those individuals and organisations who have donated.

But seven months on, we need to step up our efforts to raise enough money to take us unto and through a second year, enough for us to be able to reach out and offer work to freelance journalists and, designers.

This autumn we will be making a fresh appeal to trade union branches, regions and national bodies – but also to individual readers.

We are providing this information free to all -- but it is far from free to produce.

If you want up to date information, backed up by hard evidence, that helps campaign in defence of the NHS and strengthens the hand of union negotiators, please help us fund it.

We urge those who can do to send us a one-off donation or take out a standing order.

More details of this and suggested contributions are in the box below.

Our commitment is to do all we can to ensure this new resource remains freely available to campaigners and activists.

Without your support this will not be possible.

NAO audit of NHS finances brands them "Seriously unstable"

The day after the government signed into law a settlement in cash for the NHS of £33.9 billion over the next five years, the government's own auditors the National Audit Office (NAO), warned that years of underinvestment has led to parts of the NHS being "seriously financially unstable" and that some are building up levels of debt which they are never going to be able to repay.

Added to this are warnings from the NAO that the state of the NHS's infrastructure, some of which is older than the NHS itself, is a danger to patients due to a lack of maintenance.

NHS provider trusts reported a combined deficit of £827 million and clinical commissioning groups (CCGs) a £150 million deficit in the financial year ending 31 March 2019, according to the NAO.

The auditors noted that any extra money from the government to stabilise the finances of individual NHS bodies had not been fully effective.

Trusts in financial difficulty had increasingly turned to short-term loans from the Department of Health and Social Care to get through. The trusts treat these loans as income, and by March 2019 trusts had built up debts totalling £10.9 billion. The NAO notes: "there is no realistic prospect of this debt being repaid."

No room for efficiency savings

What is also clear, according to the NAO, is that trusts are finding it much harder to make efficiency savings and are becoming dependent on short-term measures to meet financial targets.

In 2018-19, 31% of their savings were one-off, up from 26% in 2017-18. Relying on one-off savings means that trusts must find new savings each year in addition to savings already planned.

Equipment levels, such as MRI scanners, are way lower than in other European countries

Raids on capital budget

The financial stability of the trusts is linked closely with the dire situation with NHS infrastructure - hospitals, clinics and equipment, all of which suffer from a lack of maintenance.

The budget for these things - the capital budget - has been repeatedly raided by the government; from 2014/15 to 2018/19 the government took £4.3 billion from the capital budget to fund day-to-day running costs of the NHS.

Equipment levels, such as MRI scanners, are way lower than in other European countries, and 14% of the NHS estate pre-dates the NHS (1948) and is totally inadequate for modern healthcare services.

The government also does not know what impact these repeated transfers in budget has had on patients' services, note the NAO, but with the bill for backlog maintenance standing at around £6.5 billion, and high-risk maintenance at £1.1 billion, up 139% from 2014/15 to 2018/19, the NAO conclude that there is an increased risk of harm to patients.

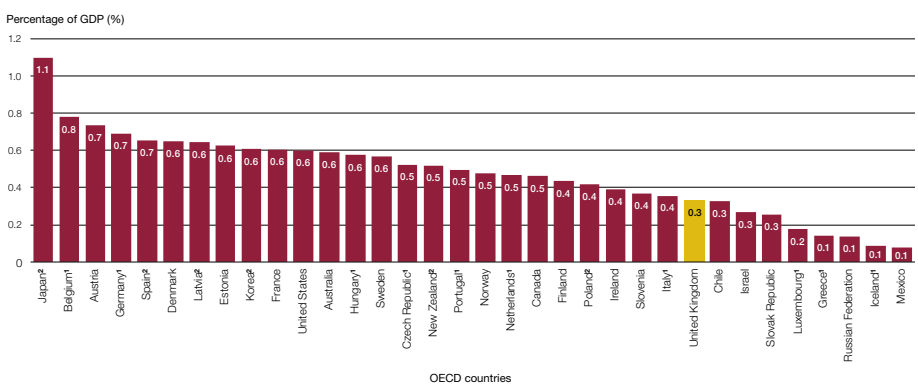
Repeated funding calls

The NHS trusts have asked for more money for capital costs - over the last three years, NHS providers have requested on average £1.1 billion per year more for buildings and equipment than their spending limits allow.

The government's approach to infrastructure spending has been piecemeal. Last year the government's promise was £2.7 billion to rebuild six existing hospitals and a pledge to build 40 in total and upgrade 20 others.

The NAO's conclusions, however, are that there is a real need to move away from such piecemeal funding promises

Figure 11
Capital investment in healthcare as a percentage of gross domestic product (GDP), 2015 or nearest year (Organisation for Economic Co-operation and Development (OECD))



Notes
1 Refers to gross fixed capital formation in International Standard Industrial Classification (ISIC) 86: Human health activities (ISIC Rev. 4).
2 Refers to gross fixed capital formation in ISIC Q: Human health and social work activities (ISIC Rev. 4).
3 Gross fixed capital formation is defined as "resident producers' acquisitions, less disposals, of fixed assets during a given period plus certain additions to the value of non-produced assets realised by the productive activity of producer or institutional units. Fixed assets are produced assets used in production for more than one year" (European System of Accounts 2010).

Source: Organisation for Economic Co-operation and Development (OECD) Health Statistics 2017, OECD National Accounts

and that DHSC, NHS England and NHS Improvement should develop a clear long-term capital funding strategy and establish a more stable funding system that is not reliant on loans.

Commenting on the reports, Anita Charlesworth, director of research and economics at the Health Foundation, said:

"The NAO has sounded a timely warning bell about the significant financial and operational challenges facing the NHS.

"Even with the government's proposed investment, the health service will struggle to maintain current levels of patient care in the face of growing demand, let alone deliver the ambitious improvements to services promised by the NHS Long Term Plan."

New strategy

A change in approach in funding is also called for by NHS Providers, the organisation which represents the 240 NHS trusts. Its report - Rebuilding the NHS - calls on the government for major investment and changes to the way capital projects are funded.

It asks the government to make investments in infrastructure akin to the national building programme in the 1960s and the investment that took place between 1999-2010; this level of investment could amount to around 100 new hospitals.

The report also calls for capital funding to "at least double" from the current £7.1 billion, and to draw up a 10-year capital investment plan so trusts can plan ahead and modernise ageing infrastructure.

The current government promises are "a much more modest ambition than what was achieved under previous initiatives", according to NHS Providers, and "the recent capital announcements, though welcome, also fall well short of what is needed."

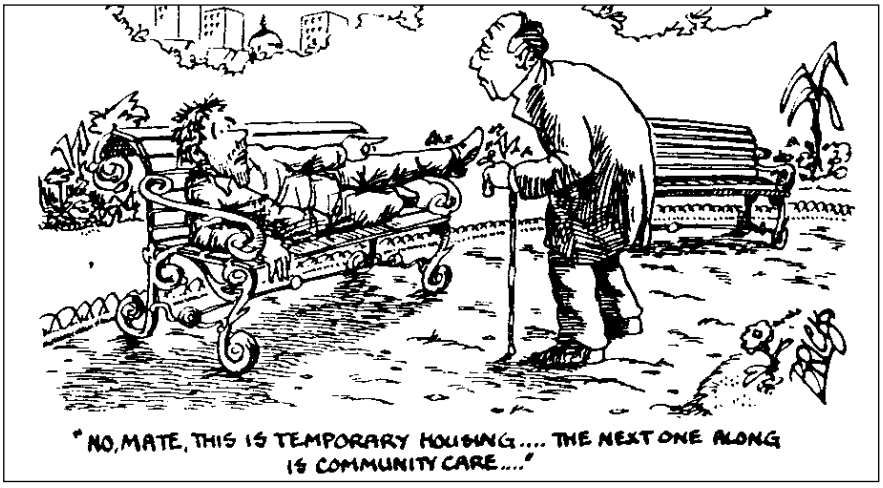
The report from NHS Providers also emphasises the need for capital funding for mental health, community and ambulance services as well as the acute hospital sector.

Holes in the budget

The widely reported budget settlement for NHS England, praised by government ministers, covers day-to-day running of NHS services, but the wider health budget which provides funds to modernise hospitals, train doctors and nurses, and run prevention services has not been given the uplift it needs.

These other parts of the NHS have had to rely on unpredictable handouts or add-ons, which mean trusts can not plan adequately.

'The NAO highlights that the NHS did not fully achieve the vision set out in the previous major plan for the NHS. Without substantial, long-term funding commitments to public health, workforce education and training, and capital, the NHS risks ending up in the same situation again.'



Councils short-changed on social care

This week the government gave the final confirmation of an additional £1.5bn for social care in 2020-21. However, council leaders were disappointed at the government failure to include any additional money to cover the late December announcement of a 6.2% increase in national minimum wage and living wage.

Councils were hoping that some additional money would be forthcoming to help them cover the wage increases. In a statement the Local Government Authority (LGA) said:

"We are disappointed that the government has not used the final settlement to provide the £220 million needed to pay for the faster than expected rise in the National Living Wage (NLW) from April..... this unforeseen new cost pressure needs to be funded to avoid the fragile care provider market being further destabilised."

Although the government touted the funding settlement at 4.4%, as the largest increase in a decade, the LGA noted that the settlement is only for one year and in order to improve services, rather than "just keep them running", a long-term funding settlement is necessary.

Furthermore, no public health settlement has yet been published, which makes it extremely difficult to plan proper services. Social care and public health are intertwined with the NHS and vital in reducing the strain on the NHS.

£1 billion of the new funding comes from the government, with the remaining £500 million being raised by local authorities from council tax rates and increasing the tax precept that provides dedicated funding for adult social care services by a further 2%.

"Crunch time" message to PM

Care England, the organisation representing companies that provide social care, has said that it is "crunch time" for the industry and has urged the Prime Minister to act on his pledge to tackle the social care crisis within 100 days of the election.

Care England's CEO, Professor Martin Green OBE, said:

"The incumbent Government has until 22 March to act upon the Prime Minister's pledge to tackle social care within 100 days of his election. The stabilisation of the adult social care sector should be the Government's first priority, inaction is no longer viable."

"The stabilisation of the adult social care sector should be the Government's first priority"

The Conservative election manifesto in December 2019 contained little on social care, just a vague plan to "build a cross-party consensus on long-term social care funding".

This followed several years of promises for a green paper on social care, but no action.

Theresa May promised a green paper in the March 2017 Budget; this followed the decision in July 2015 to defer proposals put forward by the "Dilnot Commission" and accepted in principle by the then Coalition Government.

The 2017 general election campaign included a manifesto commitment to introduce a social care Green Paper and also made a number of pledges regarding how individuals pay for their social care.

Trade unions celebrate a year of successes

It is UNION week, and it's been a busy year for Trade union members as they face the reality of a health and care system under pressure. Despite working harder than ever staff face tough threats to their pay and conditions, but they have been fighting back and with some success.

Just this week drug and alcohol support workers in Wigan announced plans to strike after their employer, Addaction refused to keep pace with NHS rates for equivalent jobs.

Staff who were transferred to the London-based charity from Wigan Council voted unanimously to take industrial action, echoing a string of similar disputes across the health and care sector.

Fair Pay and patient safety

In December and January 26,000 staff from Northern Ireland made history by striking for better pay and increased staffing, in a healthcare service currently beset by crisis.

The action coordinated by Unison, RCN and Unite brought mass media attention to crucial safety issues and won an improved deal from the government.

While the unions viewed the deal as "not perfect" it delivered an extra £60m for staffing, including an additional 900 nursing trainees and over time there will be a reduction in the reliance on agency staff

UNISON General Secretary Dave Prentis said: "Our members in Northern Ireland have not only achieved pay parity against great odds, they have won the support and respect of the people of Northern Ireland by their determination to stand up for the rights of patients and health workers alike.

Compass

Throughout October hospital cleaners, caterers, porters, receptionists and security workers went on strike over the company's failure to match health service pay rates and working conditions.

Most of the Compass employees are on the minimum wage (£8.21 an hour), yet work alongside colleagues employed directly by the NHS, where the lowest hourly rate is £9.03.

This difference of 82p an hour is worth around £1,500 a year for full-time staff, according to Unison. who levelled criticism at the company for disciplining staff that had spoken out.

In Doncaster and Bassetlaw joint action by Unison and GMB members over two days resulted in the staff being offered a pay deal matching the NHS pay scales and backdated.

Strikes in Northern Ireland were backed for the first time ever by the RCN and supported by lively pickets

Security staff in Southampton

Last year security staff at Southampton General Hospital were frequently being attacked in the A&E department by members of the public either under the influence of drink or drugs, or with mental health problems.

Their employer, Mitie was criticised for not supplying protective equipment, and employees were angry at the level of financial support offered to those who had been injured in the attacks. A two day strike led to further discussions involving officials from Unite over a new package for the employees.

Unite lead officer for health in the south east Scott Kemp said: "Unite is pleased to announce that our security staff at Southampton General Hospital have accepted a package that includes increased pay rates, improved sick pay arrangements, and new PPE equipment."

Sodexo

Back in April/May 2019, catering staff at Doncaster and Bassetlaw NHS Foundation Trust voted to take strike action over their pay conditions. After their services were privatised back in 2017, they were assured they would remain on NHS pay scales.

However the French company, Sodexo, said that pay could not be matched, "As part of the 2018 Agenda for Change pay deal, the Department of Health agreed to centrally fund new pay rates for NHS employees in England.

"However, this funding has not been extended to include those employed by private contractors, such as Sodexo.

Joint action by Unison and GMB members over two days resulted in the staff being offered a pay deal matching the NHS pay scales and backdated.

Back in-house

A thousand low-paid porters, cleaners and catering staff at Imperial College Healthcare NHS Trust in London will transfer back into the NHS, after Sodexo hands back the service contract that they have run since 2015.

As part of the transfer back to the NHS, staff from Sodexo will see their pay, overtime, pensions and sickness allowances brought in line with other health service workers, ending years of unfair treatment.

Hospitals managed by the trust include: Charing Cross, Hammersmith, St Mary's, Queen Charlotte's and Chelsea, Western Eye.

Lincolnshire health visitors

A month long strike by 70 health visitors employed by Lincolnshire County council was paused after the council agreed to the majority of the affected staff being moved up the pay scale, saving the

Bradford support staff defeated plans for a WOS

worst affected from losing £4000 a year.

Unite regional officer Steve Syson said: "Thanks to the tremendous solidarity that our members have shown since this dispute started in the summer, we have achieved a highly significant and welcome victory."

Wholly owned subsidaries

Across the country cash-strapped hospital trusts have announced proposals to develop private companies to employ non-clinical staff, taking advantage of VAT rules.

Over the last two years as plans have come forward they have been consistently challenged, and some successfully halted, in campaigns run by unions, healthcare staff and activists.

After three weeks of action and lengthy negotiations between Unison and the Trust Board, senior executives at Bradford NHS Trust agreed to drop plans to transfer porters, cleaners, security staff and others into a private company.

Eleventh hour agreement between unions and bosses at Frimley Health Foundation Trust avoided planned strike action and the planned transfer of 1000 staff to a wholly owned subsidiary - Unison, Unite and the GMB had been coordinating events including a human chain around the hospital to highlight the issue.

Privatisation

In May 2019 The High Court ruled against Circle's appeal to continue running Nottingham Treatment centre, a contract they were first awarded back in 2008, rewarding campaigners and trade unions for their joint efforts to oppose the privatisation which was reportedly earning Circle an annual profit of £2.9 million.

Circle lost this legal action against Rushcliffe CCG, leaving Nottingham University Hospital free to begin the five-year contract to run Nottingham Treatment Centre. Circle felt this decision was "flawed" and "unfair"

Get involved, share your stories and encourage people you know to join a union – more information on Union Week 2020 ***HERE.***

Lincolnshire health visitors notched up a victory

Residential care dragged down by private equity

With those involved in social care hoping for some long-term funding for the social care system in the upcoming budget on 11 March, there is another crisis bubbling slowly in the residential care sector - the precarious financial state of many of the largest private companies involved in the sector.

These companies entered the market over the last three decades to take on residential care that had previously been provided by councils. The sector seemed to be a safe bet for good returns due to the guaranteed income stream from councils and an ageing population.

But then austerity led to dwindling council resources and cuts to council budgets and suddenly the income wasn't quite as good, despite the companies charging ever inflated fees.

Private equity takeover

Since the 1980s global private equity, sovereign wealth funds and hedge funds have seen the residential care sector as a source of steady income. Hundreds of care homes passed into the control of companies with a focus on short-term investment. These companies, such as HC-One, Four Seasons and Care UK, have complex structures, including off-shore funds.

The companies have been lumbered with vast amounts of debt as the companies were sold and then restructured.

A prime example is Four Seasons, once owned by the Guernsey-based company Terra Firma, and now, due to being unable to pay its debts, owned by its largest creditor, the Connecticut-based hedge fund H/2 Capital Partners.

According to a recent Financial Times article Four Seasons "consists of 200 companies arranged in 12 layers in at least five jurisdictions, including several offshore territories." Despite the difficulties tracking the company's finances, the FT notes that it is clear that the company is laden with debt - around £1.2bn of interest-bearing debt and loans from unspecified "related" parties.

High levels of debt and the company heading for insolvency, did not deter the directors of Four Seasons from taking substantial salaries from the company; the FT reports that in 2016 the directors' pay totalled £2.71m, of which the highest paid received £1.58m and in 2017 five company directors shared £2.04m, and the highest paid received £833,000.

The behaviour of these companies has been highlighted before, the CHPI reported in November 2019 in Plugging the Leaks in the Care Home Industry, on the staggering amount of money paid out to directors, on loan repayments, and rent.

The report notes that £261m of the annual income received by the largest 26 care home providers goes towards paying off their debts, and £117mn (45%) of this are payments to related, and often offshore, companies.

If the government eventually comes up with a workable solution to the crisis in care, it's clear that some form of tighter regulation is needed for companies who run these homes.

At present the Care Quality Commission has few regulatory powers over these companies - all it can do is warn local authorities if companies are on the brink of bankruptcy to give the local authorities time to find new providers so that vulnerable people are protected.

The CHPI report recommends full disclosure of income, regulation to prevent companies with certain financial set-ups providing care in the UK, and greater involvement from the government with capital provision for new care homes.

According to the FT article, it is even now clear to people involved in the sector that more regulation is needed.

Jon Moulton, who ran Four Seasons in the early 2000s, told the FT "that regulators should be taking stiffer action, requiring care home chains to hold a certain amount of capital, much like the Financial Conduct Authority requires of banks."

Checklist or wish list?

NHS England Guidelines tighten reins on ICSs

John Lister

NHS England has now published an exhausting list of requirements for local provider trusts, CCGs and embryonic "Integrated Care Systems," (ICSs) setting them on a route march to a bizarre form of "integration".

The NHS England vision for integrated care is that the NHS be split into three main levels: neighbourhood (30,000-50,000 population), "place" (250,000-500,000) and "system" (1 million to 3 million), with NHS England and NHS Improvement controlling the whole set-up at regional and national level.

To do this they need to effectively disregard (or persuade government to change) the existing legislation – forced through by the Tory-LibDem coalition in the Health and Social Care Act 2012 – which carved England's NHS up into a market consisting of local commissioners (200+ CCGs) holding the purse strings, and providers (NHS Trusts, Foundation trusts and GPs, private – for-profit and non-profit – and voluntary sector.)

The 2012 legislation abolished the previous wider local structures (100+ Primary Care Trusts) and regional bodies (Strategic Health Authorities): now NHS England is seeking to put together a new version – so without any statutory powers or legal standing, and without any accountability or transparency at local level.

They are driving the mergers of CCGs, with 56 set to disappear in a new round of mergers from April, leaving just 135 (with more mergers planned), and reorganisation of services into 42 Sustainability and Transformation Partnership (STP) areas, which according to NHS Improvement's chief operation officer are expected to develop into ICSs by April 2021.

The NHS Operation planning and Contracting Guidance 2020/21 is the latest step towards establishing NHS England's plan: it is only 40 pages long, but densely packed, with each page studded with extra demands on local health bosses.

The common factor running through all the demands on local commissioners and providers is NHS England's determination to force them into "Integrated Care Systems" – despite the absence of any legal powers or legitimacy for such bodies to be established, and therefore little if any public accountability for their actions.

No public involvement

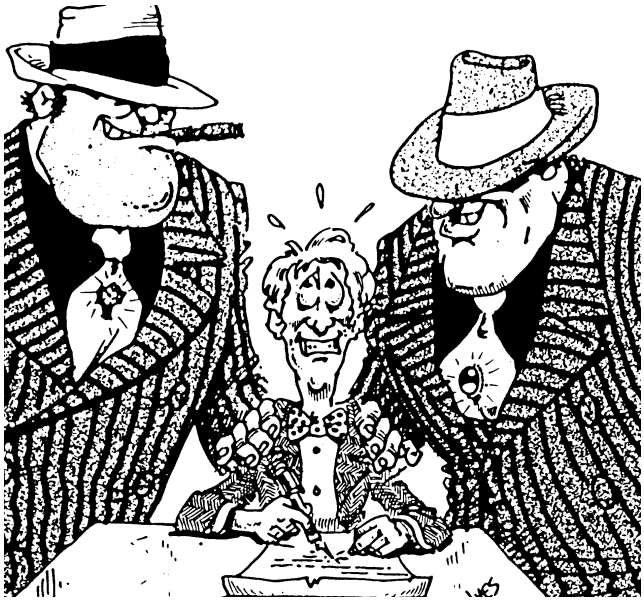
There is no mention of public involvement, engagement – or indeed of the public at all, except as the recipients of services commissioned and decided by local health systems. Instead the Introduction claims that the NHS has since last year been in a period of "stability" with the limits of its funding now set in law up to 2024:

"The NHS and its partners have used this stability to develop local system-wide strategic plans during 2019 that will put the NHS on a sustainable financial footing whilst expanding and improving the services and care it provides patients and the public."

This same blinkered approach – ignoring manifest and major problems – means NHS England makes no reference to the changes they want made to the law, which were outlined in the Long Term Plan and spelled out in more detail during last year.

The Guidance gives no indication of any concern at the lack of commitment of the Johnson government to honour its manifesto pledge to pass the necessary legislation to give ICSs legal standing, and to lift the current legal requirement on CCGs to carve local services into a series of contracts to be put out to competitive tender.

NHS England is forging ahead as if they already had their preferred version of a more centralised system in place



It now seems, according to carefully leaked rumours headlined in the Times, Telegraph, Daily Mail and Independent, that the legislation when passed will include new powers for ministers (and of course Johnson's Downing Street Svengali Dominic Cummings) to give orders to NHS England's boss, the freshly-knighted Simon Stevens.

The *Times* reports concerns of health chiefs who fear this could amount to a fresh reorganisation of the NHS. Campaigners will fear it will assert centralised control while not fully repealing the 2012 Health and Social Care Act that entrenched a costly and divisive "market" in health care.

The Planning Guidance indicates NHS England is forging ahead as if they already had their preferred version of a more centralised system in place, and spells out ways in which commissioners and providers in 42 STP areas are increasingly required to work together as a single "system".

Section 2.1 of the Guidance makes clear that ALL systems are expected to agree five separate arrangements with NHS England's regional directors which are key to them progressing to ICSs:

- **a leadership model for the system,** "including a Sustainability and Transformation Partnership (STP)/ ICS leader with sufficient capacity"….
- **system capabilities** "including population health management, service redesign, workforce transformation, and digitisation" ….
- **agreed ways of working** across the system in respect of "financial governance and collaboration" …
- **streamlining commissioning** arrangements, "including typically one CCG per system"
- **capital and estates plans** at a system level… .

Front line staff face a tough assault course of targets: "waiting lists should be lower"

These are to ensure ICSs can carry out two "core roles": system transformation and collective management of system performance (pulling individual trusts into line).

System planning

Section 2.2 of the Guidance is on "system planning", again focused on ensuring that every commissioner and provider each of the 42 systems is tied in with "local strategic plans" (few of which have yet been published). In other words the plan is to override the existing (limited) local accountability and existing statutory responsibilities of trusts and CCGs.

Section 3 sets out a tough assault course of performance targets which systems are expected to achieve. In Primary Care a tokenistic carrot of £45m of development funding is to be shared between 42 systems, while the stick includes requirements to invest in extra staff (the unfortunately named ARRS scheme (Additional Roles Reimbursement Scheme), extra doctors, delivering reductions in long waits for routine appointments, and "full delivery of online consultation systems" (whether patients want them or not).

Just £45m of development funding is to be shared between 42 systems

Community health services, with little if any extra resource are required to work to deliver "crisis response services within two hours of referral, and reablement care within two days of referral to those patients who are judged to need it" – although no details are published on how far away they are from that target, or where they are supposed to find staff and funding.

On mental health (3.2) the Guidance refers to (but does not reproduce) over a dozen rigorous "deliverables" to improve performance, despite the fact that the 135 CCGs that will exist from April have to share out a measly £135m "Long Term Plan baseline funding to bolster community mental health provision," and will get back only 40% of the salary costs of the additional trainees they will need to expand IAPT services.

On learning disabilities (3.3) along with a series of vague commitments to "ensure there is the right range of support and care services in the community", and to "increased use of Personal Health Budgets", there is a requirement to visit adult inpatients in out of

Continued page 10

Tightening the financial screws

The Guidance sets out new financial controls, with the imposition of "system control totals" that attempt to force collective responsibility for achieving these targets. This is a challenge for what have until now been relatively loose and vague agreements.

Last month the HSJ questioned the extent to which ICSs really are integrated or committed to common control totals, noting:

"to date only Dorset ICS has gambled all of its sustainability funding [SF] on meeting the collective control total. All other systems, even those that have been accepted as fully fledged ICS such as Surrey Heartlands and Bedfordshire, Luton and Milton Keynes, have resisted pooling all their SF — keeping much of it linked only to individual providers' financial targets."

It appears from the more detailed Section 5 on finances that NHS England has tacitly conceded the difficulty of this: what happens, for example if some trusts in an STP/ICS area sign up for a system control total (spending cap), but others won't? How will rivalries between big trusts in local systems be dealt with?

The political price of forcing major cuts or a closure of a trust is

"I'm not Dr Jekyll – I'm Mr Hyde the accountant"

such that NHS England has limited scope for financially squeezing those with the biggest problems.

So while the release of revenue transformation funding will depend on NHS England/Improvement approval of system plans, only ***half*** of the Financial Recovery Fund is to be tied to the financial performance of the whole system, and trusts may still get a proportion of their FRF even if they don't meet the targets.

However 50% of a trust's allocation will be based on its own performance (p30). Where they do not deliver "financial trajectories," any FRF money that has been "paid but not earnt" will be converted to additional debt ("DHSC financing").

To make matters worse (p30), organisations that miss their financial targets "will not automatically be entitled to the system element of their FRF allocation" – effectively imposing an additional penalty for being under-funded.

There are also reward payments for providers that break even or achieve a surplus in 2019/20 and 2020/21: so for the minority of relatively affluent trusts and FTs the system is very rewarding, while the others must dodge their way through penalties and mounting problems.

Section 5 on Finance (p37) also makes clear that NHS England is still tightening down on trusts and CCGs which have continued to provide and pay for treatments which are deemed to be of low clinical value: trusts will be given targets for reducing provision, and this will be further enforced by the CQC:

"Proposed activity reduction numbers by CCG, provider and ICS/STP will be provided. We will ask systems to develop their own plans with a view to meeting or exceeding these numbers. The system plans will need to be agreed with all providers and commissioners. … Performance against the Evidence-Based Interventions programme is being incorporated into CQC reviews for providers of NHS services." (p37)

Checklist or wish list?

(from page 9)

area placements every 8 weeks, and children every 6 weeks – hardly inspiring for those fearful these patients will be largely neglected and forgotten.

On urgent and emergency care (3.4) there is a historic shift away from three decades of efforts to reduce front line bed numbers:

"systems and organisations will be expected to reduce general and acute bed occupancy levels to a maximum of 92%. This means that the long period of reducing the number of beds across the NHS should not be expected to continue. …

"The default operational assumption is that the peak of open bed capacity achieved through the winter of 2019/20 will be at least maintained through 2020/21, including the 3,000 increase from October 2019 already planned for."

Credible plans

It appears that the onus is now on those seeking to reduce bed numbers, or increase by a lower amount, to produce "Credible plans to release capacity through reductions in length of stay, improvements in Delayed Transfers of Care (DTOCs), and admission avoidance programmes". But we have heard similar before from NHS England, without any let-up in the run-down of bed numbers.

Despite recent warnings on lack of capacity from the Royal College of Emergency Medicine and the Society of Acute Medicine, there is an ambitious target to increase "same day emergency care" by September, and 65% delivering acute frailty services.

And as trusts implement plans to institutionalise it, with corridor nurses and paramedics, NHS England is demanding measures to avoid ambulance delays and "eliminate corridor care".

"the long period of reducing the number of beds across the NHS should not be expected to continue"

"Waiting lists should be lower"

More ambitious still are the demands on elective care (3.5): "Specifically, the waiting list on 31 January 2021 should be lower than that at 31 January 2020. …

"Providers should ensure appropriate planning and profiling of elective and non-elective activity throughout the year, taking into consideration expected peaks in non-elective performance over winter months in order to avoid risk of unplanned cancellations.

"Waits of 52 weeks or more for treatment should be eradicated."

So easy to say, so hard to do without sufficient beds, staff, capital or revenue. Indeed if it was that easy it would already have been done.

Similarly fanciful demands follow for changes to outpatient services (3.6), reduced waits for cancer treatment (3.7), and an even more unrealistic section on public health (3.8), which simply piles on more tasks and targets without giving any baseline figures on the current state of play, discussing the cuts in funding that have been made, or identifying any additional resources.

The "People" plan (Section 4) continues the theme of wishful thinking, though it does note that the infamous promise of 50,000 extra nurses is to be delivered "by 2025," (together with 6,000 more

Dis-integrating NHS care

John Lister

While NHS England works to tighten the strings that bind so called Integrated Care Systems to central control and regional NHSE bureaucracy, the DIS-integration of local services continues with the contracting out of more services … driven by NHS England itself.

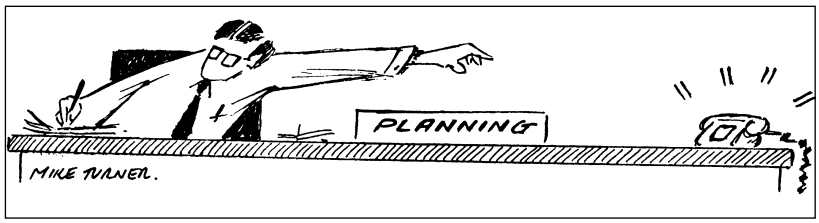
The Lowdown has reported the various moves towards privatisation in the new pathology and imaging networks that are included in the Long Term Plan.

NHS England has also set up a list of accredited companies plus a few NHS providers to offer trusts and CCGs a range of services that can "support the move to integrated models of care based on intelligence-led population health management".

The services on offer are:

- Enterprise-wide Electronic Patient Records Systems – for Acute & Community and for Mental Health Hospitals
- Local health and care record strategy and implementation support and infrastructure
- ICT infrastructure support and strategic ICT services
- Informatics, analytics, digital tools to support system planning, assurance and evaluation
- Informatics, analytics, digital tools to support care coordination, risk stratification and decision support
- Transformation and change support
- Patient empowerment and activation
- Demand management and capacity planning support
- System assurance support
- Medicines optimisation

Of the 83 accredited suppliers for these services, 76 are private companies, almost a third of them (23) US-based. Only 7 are NHS organisations.



The growth of SBS is a reminder of the commitment of the Tory government to the fragment-ation of the NHS

Among the big American corporations are McKinsey, Optum, a branch of the giant UnitedHealth (former employers of NHS England boss Simon Stevens) IBM, Centene, Cerner, Deloitte and GE Healthcare.

McKinsey has been influential in the NHS for decades, and Optum has already won contracts for a range of data-based services for the ICS programme.

Provisional wing

But while these no doubt profitable (but questionably useful, see box) services are confined to the back offices of trusts and CCGs, just before Christmas NHS England's provisional privatisation wing, Shared Business Services, widened the net.

They now include clinical care, inviting providers, including NHS, non-profit and for-profit companies, to apply to be included in a 'Framework agreement' for the supply of outsourced clinical services, including Cardiology, gynaecology, paediatric and oncology services.

This is intended to make it easy for trusts to award contracts for various services.

NHS SBS invites in various private and other

doctors working in primary care and a 26,000 increase in the wider primary care workforce).

The credibility of the proposals is not enhanced by the focus on "a significant expansion of ethical international recruitment of high-quality nurses, driven by a new national programme which will be established early in 2020."

Government erecting barriers

It appears nobody in NHS England has noticed the government's efforts to deter immigration of anyone earning less than £30,000 a year, and the associated hefty upfront costs of even the discounted NHS visa and the commitment to jack up the annual "Immigration Health Surcharge" to £625 per year.

But then the Planning Guidance appears to be more of a wish list than a check list, not so much blue skies thinking as cloud cuckoo land. Only the strings and financial penalties are real – and the extent to which these can make trusts and commissioners jump through NHS England's hoops remains to be seen.

Whether any of this can meaningfully be called "integration" is another question.

The test is in the financial discipline. While the HSJ has reported the "unprecedented" decision of the merging CCGs in Norfolk and Waveney to chip in with financial support "to help two acute trusts agree control totals", The Lowdown waits with interest to see the first trust or foundation trust running a surplus that is willing to part with some or all of it in order to ensure a local system including trusts in deficit can meet its control total.

providers into networks of approved outsourced suppliers, from whom trusts can buy in services without themselves going through a full process of competitive tendering - by simply choosing a supplier from the list (or conducting a 'mini-competition' between a few already authorised suppliers).

In other words it is batch privatisation, aimed at encouraging NHS trusts to outsource services (with the lure of varying possible "discounts") – or "insource" them, by bringing contractors into Trust premises to deliver services – rather than providing them themselves (and paying staff on NHS terms and conditions.)

Contracting out

This could in some cases mean contracting out whole units or services (and presumably transferring existing trust staff, or making them redundant).

This is at present on a relatively small scale (£117m over 2 years for clinical services, compared with an NHS England budget of around £115 billion) but clearly the aim is for this to be the start of something bigger.

Because SBS conducts all of this procurement and sets up the "framework" of privatisation centrally, allowing trusts to make OJEU-compliant appointments from its lists of 800+ "approved suppliers", it also ensures there will be even less chance of any local public discussion or consultation of the outsourcing, which might otherwise take place if decisions are made through the Trust boards, which meet in public.

The continued growth of NHS Shared Business Services and its eager promotion of private providers is a further reminder of the commitment of the Tory government to the fragmentation of the NHS and salami slicing profitable contracts for the private sector under the banner of "integration" -- while the taxpayer foots the bill, and the NHS takes the blame for the gaps and failures in an under-funded system.

No evidence to back key NHS England policy

New research in the USA has exposed the lack of evidence that costly and complex data-led attempts at "population health management," and targeting the small number of patients with complex medical and social needs (so-called "super-utilisers") who account for a large proportion of health care costs, can either reduce demand or cut costs.

A study in the New England Journal of Medicine revealed that the US "Camden model" (using a multidisciplinary team of clinicians, social workers, community health workers, and health coaches to work with patients in the hospital and then at home, with a primary goal of helping patients stay out of the hospital) had no impact on hospitalisations or associated costs in a 6-month follow-up period:

Summarising the latest findings in the Millbank Quarterly, Paula Lantz, who has analysed dozens of similar reports argues that while these "much-anticipated findings" have been described in the press and on social media as "surprising," "shocking," and "disappointing,"

"The unfortunate reality is that these evaluation results are not surprising at all. Red flags regarding the hype and overpromise of super-utilizer interventions have been waving for several years. …

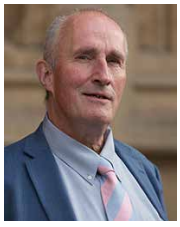
"The majority of super-utilizers live in communities facing multiple socioeconomic challenges. They also have been exposed to decades of constrained opportunities, social/environmental risks, and chronic psychosocial stress, much of which stems from institutionalized discrimination and structural deprivation. We should not be surprised that the social determinants of health create high-need/high-cost patients who do not experience sudden improvements 6-12 months after a case management intervention. …

"The truth is that hot-spotting interventions are primarily cost-containment strategies aimed at individual, very expensive patients. They are not interventions aimed at the macro- and community-level systems and institutions that drive social, political, and economic disadvantage and health inequities."

Similar findings in England have also been ignored for the past seven years by NHS England, who are throwing good money after bad on ill-conceived, privately-led and costly data-driven systems at the core of ICSs, all of which we can already predict will fail to deliver the promised results.

This is a new feature in *The Lowdown*, in which we invite observers and campaigners to air their own views on an NHS-related topic of their choice

A question of trust



Colin Hutchinson, Chair, Doctors for the NHS

One of the most controversial elements of the despised Health and Social Care Act 2012 was the establishment of NHS England as an "arm's length body", or quango, as they used to be known.

The NHS Act 1946 set out the duty of the Minister of Health to provide, or secure the provision of, the services required for a comprehensive health service in England and Wales.

The Conservative-Liberal Government's 2012 Act changed this fundamentally, to a duty to promote a comprehensive health service. At a stroke, this removed much of the ministerial accountability for the way in which services were to be delivered – "It's not me guv: blame the doctors in the Clinical Commissioning Groups, or the bureaucrats of NHSE/NHSI/HEE!"

Power grab

The Times of 8th February ("No 10 in NHS power grab"), reported that the Government is developing legislation that would fundamentally reform the 2012 Act, rather than the more limited workarounds that Simon Stevens wanted to enable the formation of Integrated / Accountable Care Organisations.

The Prime Minister apparently wants to make sure that NHSE is "appropriately accountable to the Secretary of State and Parliament" and that ministers have "sufficient levers to direct and influence NHSE". Bye bye arms' length!

Calls to stop the NHS being a political football are not new, but a service that has such a profound part to play in the life of almost every person in the country, and which needs so much funding from the public purse, cannot be anything other than a political issue.

The competence and financial commitment of the government of the day should be open to public judgment at the ballot box. What is vital, however, is for the planning of the service to be based on a much longer timescale than the five year electoral cycle.

This is not just the case with the NHS: a similarly long view needs to be taken in the response to climate change.

Commanded and controlled

Campaigners realise that bodies that were meant to offer opportunities for the public to influence local decisions - NHS Trusts, CCGs and Health and Wellbeing Boards - are nothing of the sort. They are commanded and controlled by NHSE.

That chain of command is currently strengthened by merging CCGs, aiming for one CCG per Integrated Care System.

Accountability for local services becomes increasingly remote and the ever greater involvement of commercial organisations in the planning, administration and delivery of health services means that Freedom of Information requests can be refused on grounds of "commercial sensitivity".

Bodies that were meant to offer opportunities for the public to influence local decisions … are commanded and controlled by NHS England

Things aren't great at the moment, but are they about to get worse?

Is the Government intending to take power away from NHSE, but leave accountability with the quangos – so that the Government can pull the strings while avoiding blame when the wheels fall off?

Is there a wish to strengthen the disastrous experiment in offering up the NHS to market forces and commercialisation, and convergence with the US system?

Is this move simply another facet of the turf war which has just led to the resignation of the Chancellor?

It would be lovely to believe that this Government has finally realised the folly of the pro-market policies pursued by successive governments over the past thirty years, resulting in:

- destabilisation and fragmentation of clinical services that take many years to build up;
- wilful neglect of the need to train sufficient doctors, nurses and allied health professionals, to deliver universal healthcare in every community in the country;
- the demoralisation of the existing workforce, by denying them the resources needed to deliver care to the appropriate professional standard;
- the siphoning of huge amounts of public money that should be supporting frontline services, into the pockets of middlemen and corporations whose primary aim is to extract the greatest profit possible;
- patients falling through the gaps resulting from organisations working within the limits of responsibility set out in their contracts.

Lovely

It would be lovely to believe that this Government has recognised that universal healthcare is a highly cost-effective investment in the people of this country.

It would be lovely to believe that this Government is planning legislation based on the NHS Reinstatement Bill, removing the profit motive from the NHS and harnessing the power of public service, which previously served this country well.

It would be lovely, but …