THE lowdown

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

Failed private Sussex provider still owes £11m

Coperforma, the privately-run patient transport provider still owes £11m to the NHS and its other suppliers years after its contract was withdrawn as a result of a catalogue of problems.

It was one of the most controversial failures in recent times.In 2016 Coperforma were awarded a contract in Sussex for non-emergency transport - a four-year deal worth £63.5 million with seven CCGs, replacng the NHS's South-East Coast ambulance service.

The contract was withdrawn after a matter of weeks due to shocking failures in the service. Within days problems with the contract hit headlines in the local and national press. Crews were failing to pick up patients, leading to missed appointments and patients languishing for hours in hospitals awaiting transport home.

Patients included those needing kidney dialysis and cancer patients attending chemotherapy sessions. The GMB union representing the ambulance crews said it was an "absolute shambles".

Finally, in October 2016, Coperforma were forced to give up the contract. But even now according to a report in the ***Health Service Journal*** local NHS commissioners are still trying to recover £7.6m.

Campaigners play key role in defeating North West London closure plan

Campaigners in North West London who have battled long and hard since 2012 to defend Charing Cross and Ealing Hospitals were quite rightly celebrating in the aftermath of the decision by Matt Hancock to scrap the widely hated Shaping a Healthier Future (SaHF) project (see inside pages 4-5).

Without their tenacity – and constant reference to hard evidence and a detailed critique of the plan as it evolved from a hospital merger plan to a wholesale downsizing of services covering 8 London boroughs from nine acute hospitals to just five – NHS chiefs might have succeeded in forcing through their deeply flawed plan.

Campaigners' pressure helped ensure continued resistance from Ealing council and a Labour group in Hammersmith & Fulham that fought and won leadership of what had been a flagship Tory council on a platform of fighting to save local hospital services.

Hammersmith council then took the lead in establishing the Commission led by Michael Mansfield QC which called in December 2015 for the SaHF scheme to be scrapped, and in joining with Ealing council to stand firm in rejection of the Sustainability & Transformation Plan in 2016 which also tried to push through the closures of Charing Cross and Ealing hospitals.

The delay to the plan ensured that the real, soaring costs of implementing it were revealed, and the deeply flawed assumptions of reduced demand on acute and A&E services were exposed, resulting the hospital trusts resisting SaHF's proposed massive cuts in bed numbers.

Emergency care is running above plan - A&E attendances by 9%, and emergency admissions by 16%

In other words the campaigners created conditions for the plan to effectively collapse through its own weaknesses: in similar fashion we can now see plans for controversial cuts in bed numbers drawn up in various STPs in 2016 being surreptitiously dropped as unworkable.

Had there been no resistance, these schemes might have been pushed through – with disastrous consequences.

● ***The Lowdown*** will continue to chart the evolution of STPs: see our analysis of Nottinghamshire pages 8-9.

IN THIS ISSUE

Could this really be the end of hospital waiting?

By Paul Evans

Visiting your local hospital could be a far rarer event as NHS England plan healthcare much closer to home. However, turning this vision into reality hangs on NHS leaders overcoming a big crisis in staffing.

Traditionally the next step on from your GP is the local hospital, whether it is to help diagnose or to start treatment. But NHS England has concluded that many of these trips are unnecessary and clog up an already over whelmed hospital service.

NHS leaders are working on plans to treat more of us in community settings. Instead of going to your local hospital for tests, treatment or check-ups you will be sent to a community-based facility, part of a Primary Care Network which will house multi-disciplinary teams of health professionals.

Jargon aside, this means GPs, community nurses, therapists and technicians all working together from large, souped-up health centres connected with other core services like social care. At least that's the vision, but can it be delivered?

Challenge

The size of the challenge is significant. It means a huge investment in extra buildings, community staff and technology. The government have pledged an extra £4.5bn for primary care over the next five years, but health economists are already agreed that this is not enough and will mean some tough choices.

NHS leaders have set a dizzying target to reduce the number of outpatient appointments by 30 million a year, a goal they explain in their 10-year plan for the NHS published earlier in the year.

Our hospitals contend with very high demand, outpatient care has been rising at around 3% a year and this new policy aims to put a brake on this by rerouting an army of patients towards community facilities. However, as yet these services don't exist in anything like the scale they need to.

Who will treat take on this extra work? General practitioners will lead the community teams, but they are wincing at the prospect. The number of GPs has actually fallen over the last five years.

There are now 1784 fewer GPs than there were in 2013 (full time equivalent) according to figures published by NHS Digital.

NHS leaders have set a dizzying target to reduce the number of outpatient appoint-ments by 30 million a year

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The health secretary promised 5000 more by 2020. After missing their recruitment target for two years more young GPs are finally joining, but most areas are still understaffed, particularly as older GPs are retiring at twice the rate that they were in 2010.

All this explains why many of us are finding it hard to get a GP appointment. One in five patients now has to wait at least 15 days to see a GP in England, NHS figures have revealed. Meanwhile our need for healthcare has grown, the number of GP patients has risen by 16% in the last 7 years.

Capacity gap

There is a yawning capacity gap, which has widened throughout the recent years of austerity. The problem for NHS leaders is that community services are already struggling, but the gap must be bridged if they are to have any hope of redirecting thousands of hospital patients towards community services.

Health visitors have seen their numbers fall by nearly 10% in the last five years. Many are dealing with perilously high caseloads to manage. A recent study found that some health visitors are responsible for up to 830 children – when the recognised safe limit is 250.

Staff are running the risk of being too busy to spot domestic violence or child abuse or to have too little time to catch the signs of a mother with postnatal depression.

The same pressures are evident for district nurses, who also know that their patients are getting a worse service.

"When you have a big list of patients to see in the day, if you want to get through that list, you really need to rush… you end up going and doing whatever you're there to do, but fail, sometimes, to notice that that person is actually not herself today, or something's wrong. The workload is the main enemy for the patient centred care."

Shockingly district nurse numbers have fallen by 46% since 2010, although part of this can be accounted to the transfer of staff to other providers.

Private providers like Virgin have won large contracts to provide a wide range of community health services to the NHS in Somerset, Devon and Essex and often NHS staff have transferred to work for these providers. It is unclear how this part of the market will develop, although the NHS will be in a much stronger position if it expands its own community staffing.

"The targets in the Long Term Plan don't feel particularly realistic at the moment because of the absence of any clarity about investment"

Whilst there is apprehension about the new plans, other NHS staff are more positive, as to some they about promise more cohesion and a more appropriate community-based model. There is no doubt that NHS England's vision has been powerfully painted, but even so there are worries about what is achievable.

Helen Stokes Lampard, a GP and Chair of the Royal College of GPs is supportive of the aims but has yet to see a difference on the ground

"There are workforce shortages right across the board. In the first year, the only additional employees PCNs (Primary Care Networks) are looking to take on is more pharmacists and social prescribers." (source: NHS Providers website)

Siobhan Melia - Chief Executive of Sussex Community NHS Foundation Trust commented,

"The targets in the Long Term Plan don't feel particularly realistic at the moment because of the absence of any clarity about investment"

When will the extra staff arrive and how?

The government avoided this crucial question when it published the Long Term Plan in January. Commentators noticed the hole in the plan immediately. A workforce plan would follow later the government reassured us. But getting the right level of staffing is fundamental.

One of the reasons for the delay is the extra cost that it will entail. The issue is now caught up in the wider Autumn spending review.

All government departments are vying for extra cash and the NHS is seen to have already done relatively well by avoiding outright cuts that have hit many other public services.

However, the reality is that the £20.5bn already announced is not enough to fuel improvement, economists agree on this.

So why leave the job half done? The NHS needs the investment to support a new plan to expand the NHS workforce, the whole plan hangs on it and without it the vision of community-based healthcare lacks credibility.

NHS hospitals still privatising staff with spin-off companies

The successful strikes at Wrightington Wigan and Leigh have blaized a trail

Bradford Hospital Trust is seeking to offload much of its non-clinical work to a wholly-owned subsidiary, including all its estates, facilities and clinical engineering services.

Judith Cummins, Bradford South MP, however has condemned the move by the trust saying it will worsen employment rights and make it "much easier to privatise the running of essential services."

Ms Cummins has written to Matt Hancock, Secretary of State for Health and Social Care, and the CEO of NHSI in an effort to reverse the trust's decision.

The trust says it is carrying out a full programme of consultation with staff.

In contrast, in early April Rotherham NHS Foundation Trust shelved its plans for a subsidiary following widespread opposition from unions, staff and the local MP John Healey. The trust had employed management consultants Grant Thornton to support setting up the subsidiary.

- What are spin-off companies in the NHS?
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The formation of these subsidiary companies is widely viewed as a back-door form of privatisation, which could lead to a worsening of employee rights and the creation of a two-tier workforce.

In 2018, a backlash against their formation led to NHS Improvement issuing new guidance. Plans for the subsidiaries now have to be scrutinised and approved by NHSI; Bradford Hospital Trust says that the NHSI has agreed its plans and given it the go ahead.

Hospital trusts have been enthusiastic about this approach as a way to save money and reduce deficits.

There are two ways money can be saved: through the VAT system - a private company working for the NHS is covered by different tax rules and can claim back any VAT it is charged from the Government; and, by changing the pay and conditions of staff - the companies will not be obliged to employ new staff on NHS pay and conditions but will instead be able to offer very much worse terms of employment.

A recent article in the HSJ, on King's College Hospital Trust and its subsidiary KFM, however, reveals just how complicated and even absurd the whole situation can become between a trust and its subsidiary.

It throws into question of whether this approach is a valid response to reduce a deficit.

In 2017/2018 King's College Hospital Trust had one of the largest deficits reported of £132 million and in 2018/2019 it is expected to rise to £146 million. In 2016 it set up the wholly-owned subsidiary company KFM and transferred around 60 employees.

Details from King's College Hospital Trust accounts for 2017/2018 reveal that it recorded nearly £10 million in income from KFM.

The income was from the sale of equipment to KFM, including scanners, however the £9.9 million KFM used to buy the equipment was obtained via a loan from King's College Hospital Trust, itself.

KFM only has contracts with the trust and charges the trust £97 million a year for these services. KFM also charges the trust for use of the equipment that it has just bought off the trust.

Furthermore, KFM is financially dependent on the trust, with King's College Hospital Trust having agreed to a "revolving loan facility" with KFM of £30 million.

This is due to be repaid in full in March 2027 and interest is paid at the Bank of England base rate plus 2%.

The KFM/King's College Hospital trust situation also highlights issues around accountability and conflict of interest with the subsidiary companies; until recently several board members of KFM were also finance directors of the trust.

The £9.9 million KFM used to buy the equipment was obtained via a loan from King's College Hospital Trust itself.

Yorkshire stroke units to close as national reorganisation continues

Two of five stroke units are set for definite closure in the South Yorkshire and Bassetlaw integrated care system, according to an article on Health Services Journal.

The closure will be staggered, with the Rotherham Foundation Trust losing its hyper-acute stroke care department first in July this year, followed in October by the closure of the department at the Barnsley Hospital Foundation Trust.

Hyper-acute stroke care is the very specialist care given within the first 72 hours after a stroke.

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Patients who would have gone to Rotherham will now be taken to either Royal Hallamshire Hospital, Sheffield, or Doncaster Royal Infirmary, depending on which is closest.

Those who would have gone to Barnsley will go to either Doncaster Royal Infirmary or Pinderfields Hospital in Wakefield.

Acute stroke care and rehabilitation services will still be provided at all the hospitals within the ICS, with patients moving out of hyper-acute stroke care back to other hospitals as soon as possible.

The closure of these two units was the subject of a legal challenge launched by a Barnsley resident, along with Save Our NHS groups in Barnsley and Rotherham.

In July 2018 a judge refused permission for a judicial review of the closures. The decision for the closures was made in November 2017 by the Joint Committee of the Clinical Commissioning Groups.

Stroke units have been a major target in reorganisation plans within sustainability and transformation plans written back in 2016 and now are part of plans for integrated care systems (ICS).

Kent and Medway

In February 2019, the joint committee of clinical commissioning groups (CCGs) in Kent and Medway approved plans to replace six stroke units with three hyper-acute stroke units based in hospitals in Dartford, Ashford and Maidstone.

Kent campaigners and local councillors have raised concerns about the calculations used to justify the changes, saying that the impact of longer journey times to hospitals have not been properly considered and compiled using data from London where distances are shorter.

There were also concerns about the capacity of the new system as the plan involves a permanent 16 per cent reduction in bed numbers for stroke patients, from 154 at present to 129.

■ As we reported in March (Pilot Issue #3) Medway Council has confirmed that it will seek a judicial review of the decision.

Lessons must be learned from axed North West London project

John Lister

At the end of March Health Secretary Matt Hancock finally axed the long drawn-out and shambolic project to reconfigure hospital services in North West London. He told MPs that the plan which was once held up as a model for others to follow is no longer supported by the Department of Health and Social Care, by NHS Improvement, or NHS England.

But it's not only ministers who are now distancing themselves from this failed project. Since Hancock's statement many key players, including senior figures from NHS England's shadowy London Regional office, some of whom have since reinvented themselves as management consultants, will have been praying the embarrassing details will be swiftly forgotten or buried. There is a lot for them to keep under wraps.

Soaring cost

While the headline cost of the whole scheme rocketed from £190m to over £1 billion, project costs for the hugely expensive 'Shaping a Healthier Future' (SaHF) scheme frittered away more than the cost of a substantial-sized new hospital, but delivered nothing but a stack of flawed and incomplete documents.

These included one of the largest-ever preliminary documents in the NHS (2,700 largely unread pages in 7 giant volumes of the "Decision Making Business Case" published online in 2013, a download totalling 86 megabytes).

By the end of 2017, when SaHF stopped publishing information on the costs of management consultants, local experts had already totted up official figures revealing a staggering total of £72,285,181 squandered in five years on management consultants.

However consultancy fees were only a minor component of spending on the SaHF project over the whole 7 years of the project: advisors to the Commission led by Michael Mansfield QC which investigated the plans in 2015 used actual figures from NHS reports, coupled with informed estimates, to estimate that the total costs by 2017/18 would be a massive £235m.

SaHF project leaders claimed they "did not recognise" the figures – but have never published any alternative figures to show how much has been spent. In June 2016 they revealed that a small army of 130 people, including 75 "interim executives" were employed on the project, and that more than a hundred of these would still be in post by March 2017.

Despite these lavish resources, and multiple contracts for management consultants to complete a final business case, the project which began in 2012 had not done so 7 years later.

So poor was the plan that it had its application for capital funding rejected twice by NHS England and NHS Improvement citing the very problem highlighted by campaigners – a lack of detail on how care was going to be reprovided.

By the end of 2017 local experts had already totted up official figures revealing a staggering total of £72 million squandered in five years on management consultants.

Nor did the services of consultants including McKinsey, Ernst & Young, PwC and Deloitte prevent the adoption of deeply flawed proposals. The closure of A&E services at Central Middlesex and Hammersmith hospitals in the autumn of 2014, triggered a disastrous – but entirely predictable – plunge in A&E performance standards.

It later emerged that (as critics of the plan had warned) the project leaders had made significant errors in calculating the numbers of beds required.

Only now, almost five years later and after extra beds have been opened has performance in London North West Hospitals begun to move back towards the level it was at before the closures (see graph below).

The SaHF project never won any public acceptance in the boroughs it most affected: in fact it was instrumental in the Conservatives losing control of one of their flagship London boroughs, when a Labour campaign won Hammersmith & Fulham council, pledged to fight to save Charing Cross and Ealing Hospitals.

The determination of this council to halt plans to downgrade and close local services, coupled with sustained and vigorous activity by local campaigns working together in both Hammersmith & Fulham and Ealing played a major role in delaying the process and allowing reason to prevail.

Even local trust bosses began to distance themselves from planned cuts in bed numbers.

Indeed few people who were not paid to do so ever shared SaHF's ambition to close acute services and demolish the main buildings at Charing Cross and Ealing Hospitals, and sell off most of their sites to developers, building minimal new "hospital" facilities on small residual plots.

Few people believed the heroic assumption that as yet unbuilt "community" and out of hospital services would result in drastic reductions of patients requiring emergency hospital care (99,000 fewer by 2025) and allow a net reduction of 364 beds in "outer NW London" and further cuts adding up to 500 beds overall.

Campaigners are also pressing for the Public Accounts Committee or National Audit Office to mount a rigorous external inquiry into how so much time and money was wasted

However the damage done especially to Ealing Hospital by the SaHF plan lingers on. Its services were fragmented and downgraded with the loss of maternity and paediatric services, and the looming threat of impending closure of more services and restricted scope for training doctors made recruitment and retention of medical and nursing staff more difficult.

No plans to repair damage

As yet no plans have been published to reverse or repair any of this.

The problems also extend to Charing Cross and St Mary's hospitals, part of the Imperial Healthcare Trust, which as ***The Lowdown*** reported in February has the largest backlog maintenance bill in the country, adding up to a massive £649m.

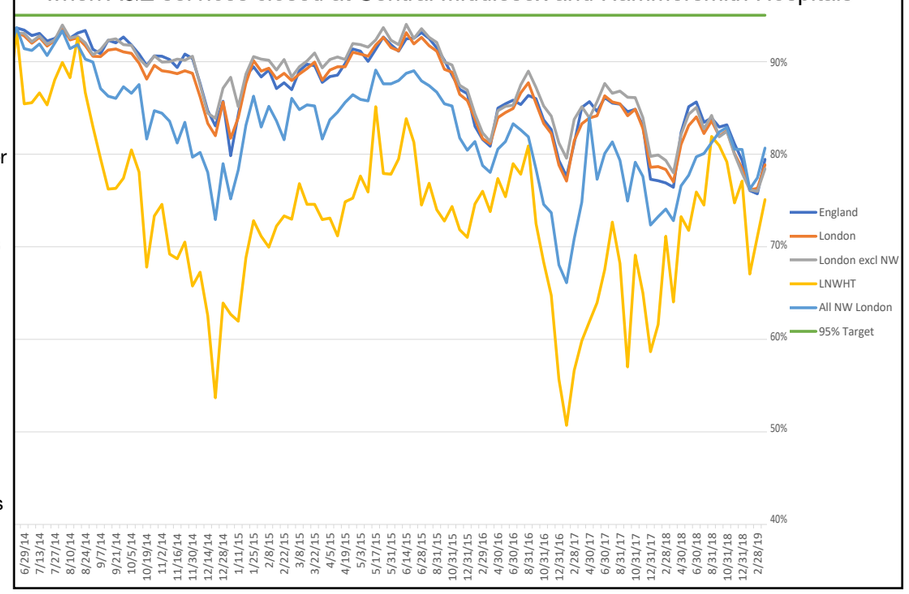
Scrapping the plans to asset strip Charing Cross to raise capital to rebuild the crumbling St Mary's, which in some cases is actually falling down, leaves the urgent question of how urgent repairs and upgrades are to be paid for while the austerity regime prevails in the NHS.

Now the plan has been scrapped and the arguments largely discredited, campaigners are also pressing for the Public Accounts Committee or National Audit Office to mount a rigorous external inquiry into how so much time and money was wasted by so many. Hopefully this will deter any NHS managers who may have looked to NW London as a model from following down the same dead end.

Some of those responsible have since scuttled off to become chief executives or management consultants rolling out similar nonsense elsewhere – and also need to be called to account.

Those who cannot learn from the errors of the past are doomed to repeat them, and any attempt to use the SaHF fiasco as a learning exercise requires a rigorous critique of why it went so wrong and wasted so much money at a time of great financial hardship for the NHS.

Still not recovered – the collapse in London North West Hospitals performance on the most serious Type 1 A&E within 4 hours, from autumn 2014 when A&E services closed at Central Middlesex and Hammersmith Hospitals



Dangerous lack of nurses affects a one in four hospital wards

By Sylvia Davidson

One in four wards in acute hospitals across England are dangerously understaffed, according to a study by researchers at the University of Southampton and Bangor University.

The study, entitled Implementation, Impact and Costs of Policies for Safe Staffing in Acute NHS Trusts, questioned 91 nursing directors, and analysed national workforce data and four case studies at NHS trusts.

Hospitals were found to be experiencing major difficulties recruiting and retaining registered nurses; the average registered nurse vacancy rate was 10% across the country, but up to 20% in some trusts.

On top of this issue, the study found that despite Government workforce data showing that the number of nursing staff has increased since 2013, an increase in patient admissions means that there has been no net improvement in registered nurse staffing levels.

Nursing support staff (e.g., healthcare assistants), however, have increased at three times the rate of RNs since 2013, and the researchers note that this results in a "dilution of skill levels in NHS acute care."

Francis Report "forgotten"?

The researchers note that the lessons from the Francis enquiry reported in 2013 into the scandal of patient deaths at the Mid Staffordshire Hospital Trust - to put patients first and never let it happen again - have "become more muted."

The RCN responded to the reports by noting that "lessons from the Francis Report are being forgotten, despite this being a once-in-a-generation opportunity to increase nurse staffing levels across all health and care settings."

This is not the first study to conclude that dilution of skills is a major issue for patient safety. Replacing RNs with lower skilled nursing assistants for health care assistants was found to be linked to a heightened risk of patient death, as well as other indicators of poor quality care, according to a 2016 study published by the journal BMJ Quality & Safety.

The study found that for every 25 patients, just one professional nurse substitution was associated with a 21% rise in the odds of dying in a hospital with average nurse staffing levels and skill mix. The researchers concluded that "diluting" the hospital nurse skill mix "is not in the public interest."

Other studies support the observation that low nurse staffing levels are associated with adverse outcomes and have shown that HCAs cannot make up for deficits in patient safety due to a shortage of registered nurses.

The government's own research institute, the National Institute for Health Research (NIHR), which is funded by the Department of Health and Social Care, agrees that the number of registered nurses is key to safety. In March 2019, it published the review Staffing on Wards, which analysed 20 separate nursing and staff-related studies that had been funded by the NIHR, and concluded that it is the number of registered nurse hours at the bedside that avoids patient harms.

For every 25 patients, just one professional nurse substitution was associated with a 21% rise in the odds of dying in a hospital with average nurse staffing levels and skill mix

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Back in 2013, recommendations from the Francis report stated that the ratio between staff and patient was of fundamental importance to safety and quality of care.

The National Institute for Clinical Excellence (NICE) produced guidance on patient-to-staff ratios for acute wards, with a 1:8 nurse-to-patient ratio after research showed that this is the level at which harm starts to occur to patients. Safe staffing data dropped

In order to increase transparency on issues such as nursing levels and improve safety, the Francis enquiry also put in place the publication of data on actual nurse staffing levels versus planned levels of staffing for each hospital trust. However, on the same day that the University of Southampton study was released, HSJ journalists reported that this measure had been "quietly dropped." The data could be used easily as a way of keeping track of how a hospital was performing.

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In the past the data has been used to show that hospitals were failing to meet their targets for nursing levels; in 2015 HSJ reported that more than nine out of 10 acute hospitals were failing to meet their targeted numbers and in 2017 the RCN used data released on the NHS Choices website to show that 45 of the 50 largest trusts in England were not staffed with nurses to the planned level.

The data was updated each month on the NHS Choices website. It showed the percentage of nurse shifts filled versus the level planned for that hospital also known as the average staffing fill rate. An important aspect of the data was that RNs and care assistants were recorded separately as studies point to the number of nurses being the key to patient safety.

New approach

Now, staff data is still being published on the NHS Choices and the MyNHS website, but using a new approach, the care hours per day (CHPD) metric; this measure combines registered nursing and unregistered care assistant shifts.

It is therefore no longer possible to find out how the care hours provided by nurses compare with the level the trust, hospital or department had been planning for, and either exceeded or fell short of – an indication of safety.

The CHPD was put forward by the Lord Carter, the NHSI non-executive director, in his 2016 review, however it has been widely criticised. The measure does not take into account the different skills within the workforce.

A major criticism is that its use could lead hospitals to employ more healthcare assistants to increase their average care hours, at the expense of registered nurses.

Based on the current trajectory there will be 250,000 vacancies within a decade if no determined action is taken to change things

Overwhelming evidence

The University of Southampton study is one of a series of studies, reviews and reports that have been published in recent years that all highlight the growing workforce issues in the NHS. There are now around 100,000 vacancies in the NHS, with many of these positions having to be filled by agency workers and bank staff at great expense to the NHS.

A report by the think-tanks, The King's Fund, The Nuffield Trust and The Health Foundation published in March 2019, predicts that based on the current trajectory there will be 250,000 vacancies within a decade if no determined action is taken to change things, including an extra £900 million per year by 2023/24 into the budget of Health Education England.

Despite the evident crisis in the workforce, the ten-year plan for the NHS, published by the Department of Health and Social Care in January 2019, did not include a workforce plan.

An interim workforce plan was expected to be published in April 2019, however this plan will not set out how the new staff role will be funded, this will take place in the autumn spending review.

Speaking to HSJ at the end of March, Julian Hartley, the national executive lead on the workforce plan, said that the plan would not say "things about priorities and investments" but "would instead set out a direction of travel for workforce policy."

Fightback as contractors' staff demand NHS pay

Catering staff at Doncaster and Bassetlaw NHS Foundation Trust are the latest to vote for strike action in a growing wave of strikes by privatised contract staff working in NHS trusts.

The Doncaster and Bassetlaw staff were transferred to private company Sodexo in January 2017 – and the company is refusing to pay them more, arguing that the government has chosen not to allocate the extra funding for contractors that it has given to NHS trusts to meet the costs of last year's increase to the Agenda for Change pay scales.

UNISON argues that the trust governors were assured catering workers would remain on NHS pay scales when they took the decision to privatise the service, and that the company has now gone back on its assurances.

Sodexo cheekily told the BBC it supports "Unison's position in lobbying the government for central funding and, if successful, we guarantee to pass that funding on to our employees".

On April 15 hundreds of members of unions GMB, Unison and Unite staged a lunchtime protest to express their anger at the shoddy treatment they have received from ISS, which employs around 600 staff across the Royal Liverpool Hospital, Broadgreen hospital and The Walton Centre in Aintree.

Cleaners, catering staff and porters, all on near the minimum wage, were facing a week without pay after ISS decided to 'upgrade' its pay roll systems to move staff on weekly pay onto fortnightly wages – leaving staff affected denied the first week's wages until after they eventually leave the company.

UNISON North West regional organiser Maria Moss said: "Most ISS workers do not have savings to draw on to tide them over. ISS's top managers don't seem to have any understanding of what life is like for the workers they employ on the minimum wage."

Meanwhile the same ISS staff will also be taking part in a strike ballot over the failure of ISS to pay them the agreed national rates of pay for NHS workers.

They will be encouraged by the recent victory of staff at Liverpool Women's Hospital where UNISON members employed by OCS took strike action, and as a result are now being paid the full NHS rates, winning a pay rise worth some £2,000 a year for fulltime staff.

The Guardian reports that an estimated 100,000 low-paid cleaners, porters, security guards and catering staff who work for private contractors in hospitals across England are being treated as "second-class employees", thanks to a growing pay divide between public and private sector workers.

Last year, as part of a three-year deal negotiated by health unions, the lowest-paid workers in the NHS were given a £2,000 pay rise . But the overwhelming majority of health staff employed on private contracts have not received a penny, according to UNISON.

Currently, UNISON says, many staff employed by private contractors are on the minimum wage, which is £8.21, equating to an annual salary of £16,052, or £1,600 a year less than what the lowest-paid worker in the public sector is paid.

STP plans ditched to make way for THREE 'Integrated Care Systems'

John Lister

Nottinghamshire is one of the eight "first wave" Integrated Care Systems being established by NHS England, and discussed at length in the NHS Long Term Plan (LTP) published in January.

It was also one that experimented with a short-term contract to enlist the services of US health insurance corporation Centene (headed in Britain by former high-flying NHS boss Samantha Jones) to help design new services, though there is now no sign of any continued US involvement.

Nottinghamshire's ICS appears to be functioning on a very different basis from the obsessive secrecy and efforts to ensure centralised control that have marred most other proposals billed as "integration".

Partly as a result of pressure from Nottingham's Labour-led City Council, under pressure from local campaigners, which walked away from the process last December, complaining of "lack of democratic oversight," the Leadership Board of the Nottingham and Nottinghamshire Integrated Care System (ICS) has agreed to hold its meetings in public, doing so for the first time in April.

It has also begun publishing its board papers and minutes of meetings.

The Leadership Board also agreed that rather than dividing Nottingham and Nottinghamshire into two "Integrated Care Systems" it will instead have three --- with a separate one for the city of Nottingham, one for Southern Nottinghamshire and another for mid Nottinghamshire. Whether this still complies with the notion of "integration" in any meaningful sense of the word is debateable.

However responding to these developments, the City Council agreed in April that it would rejoin the ICS as a full member – provided that the ICS agreed to bring in a system of unanimous voting on "any proposals that might lead to outsourcing or privatisation of NHS services."

Leadership Board of the Nottingham and Nottinghamshire Integrated Care System (ICS) has agreed to hold its meetings in public, publish its board papers and minutes

Different from Long Term Plan

So it's already clear that the process is proving very different from that spelled out in the LTP. That describes a network of ICSs to cover the whole of England "growing out of the current network of Sustainability and Transformation Partnerships (STPs)," and takes a very different approach:

"Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area." (p29).

Far from streamlining, Nottinghamshire health chiefs appear to have bought an appearance of unity by adopting a fragmented model, in which not only the council but any one of the constituent bodies would potentially be able to exercise a veto, by preventing the required unanimous vote.

In other respects, too, the Nottingham and Nottinghamshire Health and Care Integrated Care System (ICS) System Operating Plan 2019/20 shows a complete departure from much of the original STP plan that was cobbled together during 2016, and rubber stamped by NHS England at the end of that year. That plan is understandably barely mentioned at all, given that it was based on assumptions that have already proved false, including:

- Reduce "mental emergency attendances" and readmissions over the next two years by 10% (p10)
- 20-40% reduction in non-elective admissions
- 15.1% reduction in A&E attendances
- 30.5% reduction in Non elective acute bed days
- 25% reduction in admissions to nursing and residential homes
- 9.8% reduction in secondary care elective referrals (p68)

The STP's authors expected these very substantial (and largely imaginary) reductions in acute activity (a reduction of 30% in south Nottinghamshire and 19.5% in mid-Nottinghamshire, p10) would make it possible to reduce numbers of acute hospital beds – by 200 (p68).

Specifically City Hospital was to be "downsized," with its estate reduced by 20%, with further estate sales at Kings Mill (p54).

Instead the plan was to provide care in (undefined) "alternative settings that are more appropriate for our citizens."

"Care will be reprovisioned to short term residential/ community beds, short term assessment beds, standard residential beds and also supported at home living." (p69)

The STP rubber stamped by NHS England at the end of that year. That plan is barely mentioned at all: it was based on assumptions that have already proved false

STP planned for cuts in staff

According to an 11-page annex to the STP (which now appears to be no longer available online) the plans also involved a 2.7% (562 FTE) overall reduction in workforce over 5 years, centred on acute services, with a proposed reduction of 647 staff in urgent care and 691 in planned care, despite an expected 9.3% increase in demand over the same period.

In fact NHS figures show that emergency admissions, total admissions and A&E attendances have each gone up over the past two years at both Nottingham University Hospitals and at Sherwood Forest Hospitals trust. Moreover the new Operating Plan (page 86) now expects future numbers of both emergency and elective admissions to increase even faster, by 5.6% and 3.8% respectively in 2019/20, and A&E attendances to increase by 3.3%

The staffing plans have also been quietly abandoned: between May 2016 and January 2018, both acute trusts increased their staff numbers – NUH by 15%, SFH by 7.7%: only the mental health trust (Nottinghamshire Healthcare Trust) slightly reduced its numbers of staff.

The ICS Operating Plan, which went to trust boards and governing bodies in April, now faces both ways on cuts. On page 32, a diagram calls for action to save £12m in 2019/20 by:

- Reduce A&E attendances
- Reduce emergency admissions
- Reduce long term placements
- Reduce long term placement costs

Under Urgent and Emergency Care, it seeks to save £14m, by

- Reduce bed days
- Reduce long term placements
- Reduce long term placement costs

In addition, cuts in numbers of outpatient appointments are projected to save £10m, and reduction in Musculoskeletal (MKS) services is expected to save another £5m.

Mental health is also expected to save £5m – despite all the fine words in the Long Term Plan about improving access and imposing maximum waiting times for mental health care. Across the ICS there are vague proposals to save £9m from 'back office' services – which run the risk of dumping admin work onto clinical staff – and £10m from 'procurement'.

None of these proposed savings come with any detailed explanation, and there is a large caveat to the whole page highlighted in a red box which states **'Note: all opportunity figures (in bubbles) – £m– are gross, high level and indicative'.**

In other words they have little value.

Despite these apparent targets, the rest of the document appears to be proposing nothing but service improvements, and are inconsistent with the notional target of reducing spending.

Pinch of salt

However anyone seeking any serious analysis from the document should take it with a generous pinch of salt. The March meeting of the ICS Board (minutes published in April) urged anyone drafting documents always to accentuate the positive, even to the extent of inverting the facts:

"Where possible outcomes should be described as 'increases' rather than 'reductions' so they are described in a positive frame" (p4)

The same Board discussion seems to have reacted with alarm to the idea that resources might be redirected to deprived areas:

"It was queried as to whether the framework might drive resource to deprived areas which may have an impact on other areas. WS responded that this would need to be thought through; adding that reducing inequalities may mean spending differently."

Some of the most remarkable innovation is in the eccentric and jargonised use of language. We are left to puzzle for the meaning of the statement on page 40 that:

"Continuous improvement work continues on the front door pathways which started in December 2018. Working with the front door teams to allow access to back door discharge to assess services."

Is there any scope for patient care in between being speeded in through the front door and bundled out of the back? Further down the same page we find a discussion of "Options to develop additional acute capacity", which states:

"in addition to the focus on redesign, work is also being undertaken to develop potential options for the provision of additional acute capacity in case insufficient alternative schemes can be identified to mitigate the current forecast gap in capacity vs expected demand in 2019/20."

"Where possible outcomes should be described as 'increases' rather than 'reductions' so they are described in a positive frame"

Missing details

There is a striking lack of either estimated costs for some positive proposals to expand social care and reduced delayed discharge, or any workforce plan. So questions remain over plans to develop a "Home First Strategy" to provide "adequate capacity and capability within the domiciliary home care market," or the prospects if increasing "large care packages >27hrs/ week & 4x a day double ups". (p40)

Nor is there any estimate of costs or staffing implications in establishing "emergency ambulatory care", or reducing long lengths of stay in hospital "to ensure we have fewer than 199 patients in hospital with a length of stay more than 20 days". (p41)

The plan proposes to "Improve the acuity capability of community beds" but also increase utilisation of community beds "from 85 % to 92 % occupancy". (p42)

On mental health, where spending cuts are planned, the less than ambitious proposals include increasing provision of services for Children and Young People – to reach just over a third of the numbers needing support:

"Develop actions to support the 19/20 requirement of increasing access to 34% of estimated 2004 CYP prevalence" (p49)

The challenge of recruiting and adequately training sufficient mental health staff is referred to, but not the cost. Instead the ICS vaguely promises to "build towards" 1,700 new staff by 2020/21." (p50)

There are contradictory proposals to regularise use of private beds: "Transfer 16 spot purchased beds into a sub-contract in order to achieve better value and ensure care is closer to home." (p49).

Yet on the same page is a proposal to "develop a full business case for inpatient provision in Nottinghamshire Healthcare Trust." The scale of the problem of inappropriate out of area placements is enormous, with 20,488 bed days in 12 months to October 2018, and 150-180 additional beds needed by 2020/21).

The document continues in similar vein, with plans for the various provider trusts.

19% vacancy rate

But the problems faced by the trusts are glossed over. Nottingham University Hospitals for example is projecting a deficit of £68m for 2019/20: they have a 19% vacancy rate among nurses.

Mental health services are short of 158 staff including 60 nurses. Nottinghamshire is also short 77 GPs – yet the ICS plans to increase the rate of referrals of urgent care patients to GPs from 6% to 25%.

Far from any streamlined, no nonsense integration of services the ICS confirms that Nottinghamshire's NHS remains divided on many levels, locked in a crisis lacking staff, funds and beds, and dogged by continued production of hopelessly vague and unrealistic plans which are discarded some time later without learning any lessons.

■ In future issues of ***The Lowdown*** we will investigate other ICS plans to see if this is the norm.

Why are NHS mental health services still in crisis?

One in four people will experience a mental health problem each year, but most go untreated. Extra funding and new approaches have repeatedly been promised by ministers and by NHS England, but a recent Parliamentary assessment revealed that the service is still letting huge numbers of mental health patients down, why is this?

Summary:

Staffing levels are not rising with demand - scope and standards of care falling

Funding has been insufficient, and money has not reached patients

Our society is not addressing the root causes of ill health, over relying on drug solutions

Targets to treat mental health patients with same priority have been missed

Planners of care don't adequately involve people with a lived experience of mental health

NHS mental health beds have been cut and services outsourced

Rising number of patients

A recent study looking at young people found a six-fold increase over the last two decades, in the proportion of 4-24 year olds who have a long-standing mental health condition.

Commenting on the Nuffield Trust research, Dr Dougal Hargreaves said

"We know that there is already a growing crisis in the availability of Child and Adolescent Mental Health Services, with many more children and young people needing treatment than there are services to provide it."

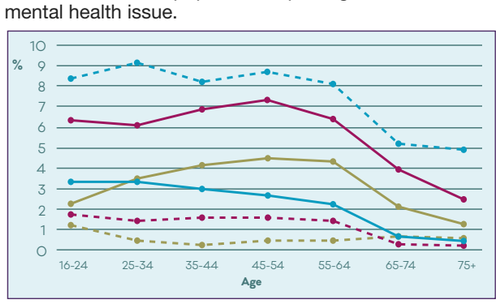
The authors suggest that part of the reason for the growth in demand is the willingness to admit problems.

The evidence also shows a steady rise in mental health issues across the population as a whole.

Economic uncertainty, the influence of social media and rising expectations of life have been suggested as factors.

92% of mental health trusts said in a recent survey that changes to universal credit and benefits are increasing demand for services, as are loneliness, homelessness and wider deprivation.

The most recent figures from NHS digital (2014) shows 9.3% of the population reporting a common mental health issue.



Prevalence of common mental health problems by age, from Mental Health Foundation Fundamental Facts about mental health 2016

The most recent figures from NHS digital (2014) shows 9.3% of the population reporting a common mental health issue

Staff numbers have not kept up with demand

In 2013 there was 1 mental health doctor for every 186 patients accessing services. In 2018 this has fallen to 1 for every 253 patients.

The number of nurses per patient has also dropped. In 2013 there was 1 mental health nurse for every 29 of patients accessing services, by 2018 that had fallen to 1 for every 39 patients.

10% of specialist mental health posts are unfilled.

A survey by UNISON of staff working in mental health found that staff shortages were:

- a major factor preventing individuals from accessing services early (74 per cent)
- a reason for the increased frequency of violent incidents experienced in the past year (87 per cent)
- a reason for staff having to work unpaid overtime (57 per cent).

Last year it was reported that two thousand mental health staff a month are leaving their posts in the NHS in England, according to figures from the Department of Health and Social Care (DHSC).

Funding is insufficient

An analysis of the most recent budget (2018) by economists at the Health Foundation noted that,

'Extra investment in mental health services will see funding grow broadly in line with the total health budget but this will mean simply maintaining the status quo, which sees just 4 in 10 people who need it receive mental health support. To see some improvement, with provision increasing to 7 in 10, the service would need an extra £1.5bn on top of what the chancellor has announced."

An overwhelming majority (81%) of trust leaders said they are not able to meet current demand for community CAMHS and more than half (58%) said the same for adult community mental health services; more than half (56%) could not meet demand for crisis resolution teams.

Commissioners don't involve people with a lived experience of mental health

A report by the charity Rethink found that only 1% of clinical commissioning groups co-produce their mental heath services with users and carers, they concluded

"Decisions about complex care need to involve the people using them." CCGs are failing to adopt co-production despite the fact that it was set out as the standard approach in the mental health strategy produced by NHS England.

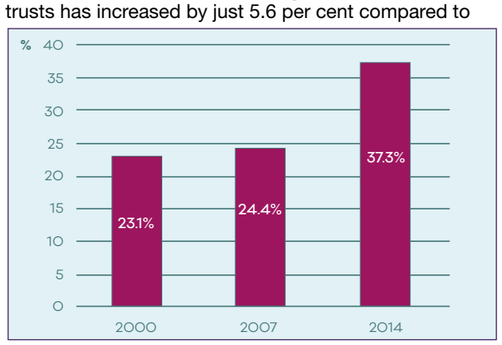
Mental health is still given less priority than physical health

There is less stigma attached to mental health services, but they only received 13 per cent of the NHS budget despite the fact that mental ill health accounts for 23 per cent of the disease burden.

For three years in a row, 40 per cent of mental health trusts received a cut in their funding (2013-2016) according to research by the Kings Fund. In the last year (2017-18) 21 per cent still suffered a fall in income.

Overall, since 2012/13, funding for mental health trusts has increased by just 5.6 per cent compared to an increase of 16.8 per cent for acute hospitals.

This is despite the government have stating its commitment towards achieving parity between mental and physical health back in 2011, and has led to accusations that mental health funding is not reaching patients and according to a Nuffield Trust analysis is being diverted to cover outstanding debts.



Percentage of people with common mental health problems in 2000, 2007 and 2014 receiving treatment, from Mental Health Foundation Fundamental Facts about mental health 2016

NHS Providers infographic 2019

91% of trusts blamed council cuts as a reason for more demand for mental health services

Closure of mental health beds and other services

The number of beds for mental health patients in England has slumped by nearly 3,000 (-13%) since 2013.

Official figures show that the number of beds for those with some of the most serious conditions – including psychosis, serious depression leading to suicidal feelings and eating disorders – has fallen from 26,448 in 2009 to 18,082 in 2018.

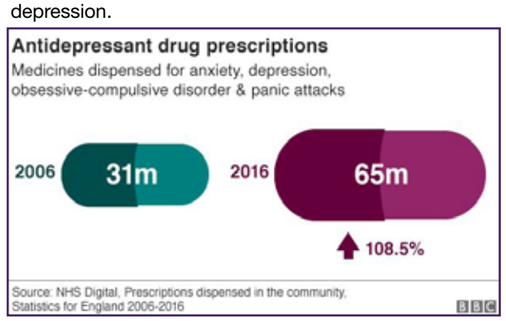
91% of trusts blamed council cuts as a reason for more demand for mental health services.

"Cuts to services funded by local authorities also mean that preventative approaches and early intervention services are less available. Mental health leaders pointed to rising demand during winter, but it is clear that these pressures on services are a year-round phenomenon." - (NHS Providers survey of trusts).

Neglecting the root causes and over relying on drug solutions

As a society we are not adequately addressing the root cause of mental health; economic uncertainty, problems with housing, social isolation, relationship breakdown and chronic disease.

More people are sleeping rough and one in five of us have mental health issues connected to housing, changes to benefits have increased suicides, a million children are living with parent who is addicted to alcohol and two fifths of people in care homes suffer depression.



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.*

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

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

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

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

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

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

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

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

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

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

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

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

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

Why is it needed?

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

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

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

In our first year we will:

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

Help us make this information available to all

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

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

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

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

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

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

On the website 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