THE lowdown

Health news, analysis and campaigns.
NUMBER 10, Sept 28 2019

Informing, alerting and empowering NHS staff and campaigners

£200m for scanners

As we publish this issue (28 Sept) Prime Minister Johnson is set to announce a £200 million cash injection to replace MRI machines, CT scanners and breast screening equipment.

Of European countries only Hungary has fewer MRI and CT scanners per head than the UK. Delays are growing and targets are being missed in the treatment of cancer.

The Health Foundation estimates much more (£1.5bn) would be needed to bring the UK up to EU average provision.

The funding that has now been promised is expected to provide 300 diagnostic machines in hospitals across England, although the ancillary costs of modifying or extending buildings and facilities are not covered.

Johnson's promise received a critical response from Cancer Research UK, which told ITV News that the machines themselves are not enough: staffing shortages in the NHS need rectifying as a priority. **"These new machines will only work if there is staff to operate them."**

Shadow health secretary Jonathan Ashworth said Mr Hancock was "yet again following our lead" with the announcement. The Department of Health said the machines, to go to more than 80 trusts, will improve efficiency and improve patient safety by delivering lower radiation levels.

Meanwhile NHS England has been seeking to push through plans that fragment and privatise the provision of specialist PET-CT scanning services in Oxfordshire and elsewhere.

Labour backs call to scrap NHS charges

In what seems certain to be the last Labour conference before a further general election, decisions were made to call on a future Labour government to scrap charges that stand as an obstacle to people accessing the NHS treatment they need.

A wide-ranging composite motion called for repeal of sections 38 and 39 of the 2014 Immigration Act and subsequent regulations which enforce up front charges of 150% of the cost of treatment on people who cannot prove they are normally resident in the UK.

Shadow Health Secretary Jonathan Ashworth had earlier lent his support to this proposal at a conference fringe meeting and it's likely to survive Diane Abbott's subsequent statement that Labour will not take on all of the points of the immigration motion.

Nye Bevan, founder of the NHS insisted that services should be free to all, and rejected calls to charge "foreigners," arguing it would raise little money but require everyone to prove identity. Theresa May's racist "hostile environment" policies scrapped this principle, and NHS trusts are now required by law to check patients are entitled to free care.

Save Lewisham Hospital Campaign discovered that 18% of 9,000 women who gave birth in 2017/18 in Lewisham and Greenwich hospitals were challenged to prove their entitlement to NHS treatment, and 541 were charged £6,000-£9,000 for their care.

Nye Bevan rejected calls to charge "foreigners" arguing it would raise little money but require everyone to prove identity

Now the Royal College of Midwives has demanded these charges be suspended until it can be proved they are not harming women.

BMA vice chair David Wrigley has also warned that doctors will not assist the imposition of a "hostile environment": "It is a doctor's job to treat the patient in front of them, not determine how the treatment is being paid for."

People fighting to scrap the charges will of course have to combat the right wing media and their false and malicious claims on the costs of "health tourism".

■ An additional positive step forward was Jonathan Ashworth's speech committing Labour to scrap NHS prescription charges, which currently only apply to ten percent of prescriptions in England – while Wales, Scotland and Northern Ireland have already abolished them.

Citing the tragic example of 19-year old Holly Warboys who died because she couldn't afford an inhaler, Ashworth said:

"People shouldn't have to pay to breathe. Prescription charges are a tax on illness. I can confirm the next Labour government will abolish all prescription charges."

IN THIS ISSUE

NHS England calls for new legislation to scrap compulsory tendering

John Lister

While Prime Minister Johnson seeks pre-election voter popularity by reeling off a series of promises of "extra" funding that falls short of reversing the real-terms funding freeze that has squeezed the NHS for the past nine years, NHS England has drawn up a shopping list of reforms it wants pushed through Parliament in new legislation.

The Guardian report flagging these up is optimistically headed "NHS privatisation to be reined in under secret plan to reform care."

It states that the proposals, drawn up by NHS England and NHS Improvement after protracted engagement with various organisations and individuals, are expected to feature in the Queen's speech next month.

The most substantial proposals centre on repealing section 75 of the 2012 Health & Social Care Act and the sections establishing the Competition and Markets Authority's (CMA) roles in the NHS, and going further to remove the commissioning of NHS healthcare services from the jurisdiction of Public Contract Regulations 2015, and abolish Monitor's specific focus and functions in relation to enforcing competition law.

End compulsion to tender

Between them these changes would remove the compulsion to put NHS healthcare services over £615,000 a year out to competitive tender. As such this proposal has been welcomed by UNISON's Head of Health Sara Gorton, who said:

"This is long overdue. These proposals would protect the NHS from the worst excesses of privatisation and end the situation where different parts of the health service have had to compete against each other."

UNISON has joined with 17 other organisations including NHS Providers and the Local Government Association in signing a letter calling for a Bill to be included in the Queen's Speech, which "should be tightly focused on the issue of care integration to foster collaboration within the sector, including removal of section 75 of the 2012 [Health and Social Care] Act with its unnecessary procurement processes."

The proposals set out by NHS England and NHS Improvement would not reverse any of the privatisation that has already taken place, or prevent NHS England, CCGs or NHS trusts from choosing to put further services out to tender

But while they are welcome as far as they go, the proposals on Section 75 and competition set out by NHS England and NHS Improvement are for many seen as a starting point rather than a satisfactory conclusion.

They would not reverse any of the privatisation that has already taken place, or prevent commissioners, NHS England or NHS trusts from choosing to put further services out to tender.

Not far enough

The proposals certainly don't go as far as Shadow Health Secretary Jonathan Ashworth feels is necessary. Ashworth led the unsuccessful opposition in Parliament to regulations laying the basis for Integrated Care Partnership contracts, and he is concerned now about the limitations and implications of the rest of the proposed Bill, which heads along similar lines.

He told the HSJ:

"We want to see the Lansley Act repealed, we want to restore a public universal NHS. We want to end fragmentation, to see care delivered on the basis of planning, not on the basis of markets and competition."

The GMB union, which has also campaigned for the removal of Section 75 and its regulations, also argues that the new Bill does not go far enough.

Other proposals put forward by NHS England include:

- Some apparent concessions on local accountability in an attempt to win wider acceoptance of new Integrated Care Systems – even though these would be functioning outside the existing legislation:

"NHS England and NHS Improvement should develop statutory guidance on governance of ICS joint committees. To increase transparency, ICS joint committees should not only meet in public, as recommended by the Select Committee, but also hold an annual general meeting, and publish an annual report. Their decisions would also be subject to scrutiny by Local Authority Overview and Scrutiny Committees."

- Tariff changes and a new procurement regime to "guard against the risk of introducing competition solely on price as opposed to quality."
- A new 'triple aim' for NHS commissioners and providers alike, of "better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer."
- Allowing NHS commissioners and providers to form joint decision-making committees on a voluntary basis, "rather than the alternative of creating ICS as new statutory bodies, which would necessitate a major NHS reorganisation."
- Local authorities should be able "actively encouraged to join ICS joint committees" with full membership – as long as they do not interfere on decisions over cutbacks and closures ("not introducing a new local government veto over the NHS's discharge of its own financial duties")

● Changing the 2012 Act to support the creation of integrated care providers as NHS trusts, and to ensure that "only statutory NHS providers should be permitted to hold NHS Integrated Care Provider contracts."

A number of NHS England's initial proposal have now been dropped, most notably "NHS Improvement's proposed power to direct mergers between Foundation Trusts", which was rejected by the Select Committee, NHS Providers and the NHS Confederation, and "not supported by the NHS Assembly".

It's a mixed bag, in which only the retreat from further privatisation is explicit. Campaigners would be critical of many of the other proposals.

Whether the Bill even appears in the Queen's Speech, and whether it might be passed through the Commons, given the government's lack of a majority and the quite deliberate stoking up of opposition anger as Johnson has tried to force an early election that could enable him to push through a no-deal Brexit on October 31, is an unanswered question.

No chance in Commons

Jonathan Ashworth has argued that the government "has got no chance" of getting the NHS Integration Bill through Parliament: "I'm not convinced [health secretary] Matt Hancock will go as far as what is needed to provide the care that patients deserve. The Conservatives have lost their majority and, as things stand, I think Mr Hancock has got no chance of getting any legislation through at the moment."

The invitation to NHS England to take the lead in formulating the scope of legislation to deal with the fragmentation and contracting out of services entrenched by Andrew Lansley's 2012 Health and Social Care Act first came from Theresa May in the summer of 2018. Outline proposals were included in the NHS Long Term Plan published back in January.

But since then many aspects of the situation, and most of the cabinet have changed: last November Health Secretary Matt Hancock made clear the government would only proceed if Labour would effectively sign off on the NHS England proposals without amendment or addition:

"Crucially… if we bring this bill forward and people add things to it that don't work, or cost too much money, or are going to cause us problems, then we may have to drop the bill altogether. And it will be the people bringing forward additional baubles whose fault that would be, not mine."

It seems that the NHS Integration Bill, like so many other policies in these uncertain times, is far from a done deal, and certainly not the far-reaching package of legal changes most campaigners want to see.

Unlike most of Johnson's announcements, which have aimed to lure voters with the dubious promise of extra cash, these legal changes will be understood by few people, and are unlikely to grab the attention or support of many voters.

That's why, even if he does get the nod to push it forward, Hancock is clearly preparing to duck and run if he can't get the support he wants, and faces too many awkward questions.

Duty-free promise to distract us all from no-deal worries

Ministers are now publishing correspondence with the EU negotiators that reveals the extent of their gross failure to prepare for the disastrous no-deal outcome they have been relentlessly steering towards since Johnson took office as PM.

But relax: according to the Chancellor, however appalling the situation after Britain crashes out with only WTO rules to trade upon, those of us who can still afford to travel to the EU will be able to take comfort in the old-fashioned pleasure of … duty free booze and fags.

A government press release on September 10 headlined "Chancellor announces return of duty-free," and enthused:

"Passengers travelling to EU countries will be able to buy beer, spirits, wine and tobacco without duty being applied in the UK, **thanks to the lifting of EU rules."**

"For example, a holidaymaker could save more than £12 on two crates of beer. The travel industry has been calling on the government to re-introduce duty-free, **which stopped when the EU Single Market was introduced**."

The prospect of Brits drowning their sorrows with large quantities of duty-free drink and puffing their way through bulk buys of tobacco will no doubt add to the concerns of public health experts, who were already warning that a no-deal Brexit is a threat to public health.

A letter to the Guardian signed by 29 leaders in public health warns that:

"Brexit is proceeding at a time when the long-term improvement in life expectancy has slowed and, for some age groups, gone into reverse, while the most vulnerable in our population face growing insecurity of income, employment and even food.

"We believe that all of these would be exacerbated by a no-deal Brexit."

The health threat from a no-deal comes in addition to the growing problems of social inequality that are driving a deepening of health inequalities: the latest analysis shows a massive 16 year difference in healthy life expectancy between different areas of Britain – as wide as the gap in life expectancy between Britain and Sudan.

The people with the fewest average years in good health were in Blaenau Gwent in South Wales, with just 54.3 years: the highest healthy life expectancy in Britain is in leafy Wokingham, at 70.7 years: the national average is 63.6 years.

No medicines or food? No worries with cheap booze & fags!

Now it's official: CCG mergers aim to drive through "majority" plans

CCGs don't offer much resistance now, but management hope merging them, and creating "Integrated Care Systems" can speed through controversial changes with less opposition

As we have discussed in previous issues of The Lowdown, the controversial process of merging Clinical Commissioning Groups is well under way. John Lister gives an update.

If NHS England gets its way the days of any local accountability of Clinical Commissioning Groups (CCGs) could be numbered: according to an HSJ report NHS England is stepping up the pressure for groups of CCGs to merge: the latest proposals could see the current 191 CCGs in England reduced to just 40.

However one planned merger – of the six CCGs in **Staffordshire** – has now been formally scrapped after a majority of GPs in five of the CCGs voted to reject the idea. The merger plan had already been criticised as a "cost-cutting exercise" which had no benefits for patients by the Alcott, leader of Cannock Chase Council.

The GPs were told the plans were "driven by NHS England", by Dr Paul Scott, chair of the North Staffordshire Local Medical Committee, who advised his members to reject the merger. He wrote in an email, seen by HSJ:

"Much has been made of the potential benefits of having a single CCG in Staffordshire, yet few if any of these arguments hold true or are at best speculative."

Minimise local voice

Campaigners have argued that one of the reasons behind this drive to merge CCGs into such large units is to minimise any local voice or dissent while controversial closures and downgrades of hospitals and services are pushed through.

Now there are explicit statements from senior NHS management that confirm this is the case.

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

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

Councils of various political complexions in London and elsewhere have warned of the impending loss of accountability: in **Essex,** where there are plans to merge 5 CCGs, the Conservative Leader of Thurrock Council, Cllr Rob Gledhill said:

"We understand the need for the NHS and all public sector bodies to work as efficiently as possible, but that should not be to the detriment of residents who rely on the vital services our local CCGs are involved in providing.

"Creating a single CCG responsible for commissioning health services for 1.2milllion people across south and mid Essex would not only be a huge challenge because of the sheer size of the area, but would result in the loss of local accountability and would be a real waste of the excellent local partnerships that have been formed.

"By taking a more centralised approach, we also fear that the different needs of patients and local priorities in the 5 areas would not be fully taken into account. We would strongly urge NHS England to think again about these dreadful proposals to avoid irreparable damage to a health service we are all very proud of."

Council health and scrutiny committees, which still retain powers which date back to the 1970s to delay and challenge changes in services, may become the last vestige of local account-ability in an "integrated" NHS

Telford says No

In **Shropshire**, Shaun Davies the Labour leader of Telford & Wrekin council, which has been fighting against the 'Future Fit' plan to downgrade the local hospital and move services to Shrewsbury, has also come out firmly against a merger of CCGs: he warns that any merger between the two CCGs would see health funding and resources being diverted out of the borough to Shropshire.

Telford and Wrekin's CCG has a balanced budget while Shropshire CCG has had a mounting budget deficit, currently at around £28 million. Cllr Davies said:

"This is simply Telford and Wrekin being fleeced to sort out Shropshire's financial problems and years of poor management. This feels like the whole 'Future Fit' debacle again - Shropshire takes over, Telford and Wrekin loses out, robbed to pay off Shropshire's debt."

In **North West London**, where another 8 CCGs are set to merge into the biggest CCG covering 2.2 million people, NHS bosses are still smarting from the collapse of their 7-year effort to force through hospital closures affecting two boroughs, Hammersmith & Fulham and Ealing: a merged CCG would be even more remote from local campaigners.

That's no doubt why, despite regulations requiring them to do so, few if any of the planned mergers involving 86 CCGs have involved any genuine public consultation, or taken any real notice of the views of local councils which in theory should be regarded as partners.

The mergers are another top-down bureaucratic reorganisation.

If NHS England brazens it out and pushes through these mergers, council health and scrutiny committees, which still retain powers which date back to the 1970s to delay and challenge changes in services, may become the last vestige of local accountability in an increasingly centralised and monolithic "integrated" NHS.

In our first year we pledged to:

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

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.**

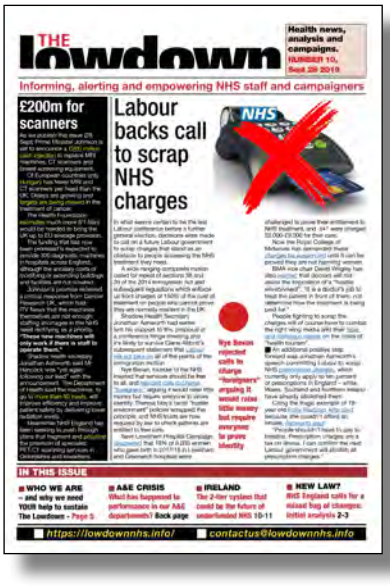
Our mission is to inform, explain, analyse and investigate issues and ensure that the founding principles of the NHS are upheld, in policy and practice.

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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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.

Help us keep The Lowdown running in 2020

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

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.

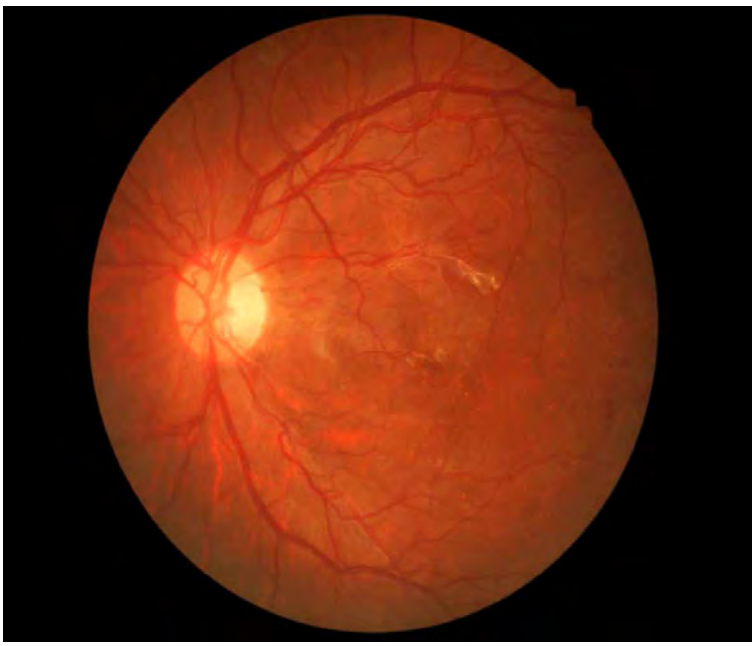
We know from our surveys that many readers are willing to make a contribution, but have not yet done so. We are now asking those who can to give as much as you can afford. We would suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can 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.

On the website we will gratefully acknowledge all of the founding donations that enable us to keep this project going into a second year.

- 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*

Manchester campaigners' eyes are on private takeover of screening service



You need a GCSE to do this stuff

On April 1 diabetic eye screening services for all of Greater Manchester were moved from NHS hospitals and opticians to the private company Health Intelligence (HI), which describes itself as

"a leading software provider of information management solutions for health organisations in the UK. Our main areas of focus are on Diabetic Eye Screening services and population based data analysis to improve Long Term Conditions diagnosis, promote prevention and identify cost savings."

Subsidiary

HI is a subsidiary of InHealth, the provider of managed diagnostic services and healthcare solutions to the NHS, which has been embroiled for months in a row over a contract to deliver PET-CT scanning services in Oxfordshire, Swindon and Milton Keynes.

The privatisation was not the result of any failures by the NHS: patients were told "Health Intelligence, the new provider, will continue the excellent service you used to receive."

Instead of investing more in hospital services, NHS England last year commissioned two 5-year contracts for diabetic eye services (the combined contract was tendered with an estimated value of £27m).

Because each part was worth over £615,000 they had to be put out to tender: and HI won.

Previously these services were centred in-hospital at Salford Royal and Central Manchester, and at high street opticians. Now they will all be centred at HI's chosen facilities.

Access to consultants

In hospitals screeners have access to consultants for advice on the grading and interpreting of images of retinopathy. Now some of the staff formerly employed by the NHS have been taken on by HI, but without the access to a consultant.

In Greater Manchester, no high street optometrists are being employed for screening and hospital screeners who were previously employed by the NHS are now employed by HI.

It is not clear whether other HI staff will have been trained to NHS-equivalent standards.

In London in 2016 their diabetic screening was carried out by 10 local optometrists, clinical leadership was sub-contracted to a private consultant, slit lamp biomicroscopy was provided by another private provider, and results were graded by six private sector individuals.

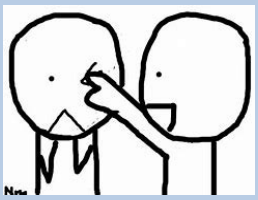
The company has a number of advertisements for retinal screener/graders, 'working unsupervised', with senior retinal screeners helping monitor the retinal screeners together with Team Leaders.

A poke in the eye

Everywhere in Greater Manchester: diabetic eye screening run for profit

Bolton cataract eye surgery: run for profit

Reverse privatisation of NHS eye services in Greater Manchester!



GCSE required

The salary is £18,500 and requires candidates to be educated to GCSE level and they must complete the Diploma in diabetic retinopathy screening.

Since 2011 HI have previously taken over diabetic eye screening in at least 9 counties (Suffolk; Essex; Middlesex; Kent; Hampshire, Dorset, Berkshire, Somerset, Devon and Cornwall).

Before if you went to a high street optician, they have been extensively trained in screening for diabetes which often has not been previously diagnosed. Now in Greater Manchester they can no longer screen you, but will have to refer you to back to your GP who will then refer you to HI.

After High street and hospital staff told campaigners that they are worried about patient safety under the new arrangements the campaigners are now calling on Greater Manchester Mayor Andy Burnham to join them in demanding that local health commissioners (the Greater Manchester Health & Social Care Partnership) end the contract with HI and bring this service back in house.

Campaigners are calling on Greater Manchester Mayor Andy Burnham to join them in demanding health chiefs bring the service back in house.

In Bolton...

Cataract eye surgery has been privatised to the for-profit company Spa Medica, which has contracts elsewhere and is connected to SSP Health Ltd which manages 37 GP practices across the North West.

Up to 98% of patients in Bolton are using Spa Medica, but several have told us that they weren't offered any choice of using the hospital, but were sent direct to the private company.

Some diabetic eye screening is now being done at SSP Health's Bolton office.

The campaign can be contacted via ***https://keepournhspublicgmcr.com/***

Battle for fair pay from contractors

September has been a month for industrial action by staff employed by contractors – especially in the North West.

Engie

The latest to join the fray have been staff employed by private contractor Engie Services Ltd within Salford Royal NHS Foundation Trust have unanimously voted to take strike action over their employer's failure to pay NHS rates.

They work for the multinational outsourcing company as security guards and some are paid only the minimum wage rate of £8.21 an hour. The lowest rate for staff employed directly by the NHS is £9.03 an hour and the difference of 82p an hour is worth £1,500 a year for full-time staff.

UNISON North West regional organiser Amy Barringer said: "Security staff put themselves in danger to keep patients and staff safe. The 100% mandate for strike action shows how strongly these dedicated hospital staff feel about this issue. Engie must put hands into pockets and do the right thing before hospital security staff are forced to take strike action."

Compass

Around 300 staff employed by private contractor Compass within NHS trusts in St Helens and Blackpool have also taken three days of strike action – angered by the company's failure to match health service pay rates and working conditions.

UNISON has condemned Compass for silencing its workers, after the firm disciplined hospital workers at St Helens & Knowsley Teaching Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust who had spoken out about low pay.

UNISON regional organiser Pat Woolham said: "It's plain that Compass is aiming to silence the strikers and suppress staff in an attempt to force them back to work. But the strikers are united, determined and will take further action if necessary."

The September action is the third round of action on the issue by these hospital workers.

Addaction

In Wigan 31 drug and alcohol support workers employed by Addaction are have been taking action over pay and broken promises. The staff were previously employed by the NHS but the service, commissioned by Wigan Council, was transferred to the London-based charity.

Workers continued to receive pay rises in line with those of NHS employees and were given assurances by the organisation's managers this would continue into the future. But when the 1% pay cap in the NHS was removed from April 2018, Addaction refused to implement the promised wage rise.

Chamber of Commerce fights to stop Cheltenham downgrade

An unusual but potentially powerful campaign against the downgrade of A&E and acute services at Cheltenham Hospital is being led by … the local Chamber of Commerce!

The challenge from this unlikely quarter has been triggered by the launch of Gloucestershire Hospitals Foundation Trust of a 'Fit for the Future' document which campaigners – and now business leaders warn is misleading. They have analysed the proposals and rewritten the questions it asks, to pose the issues more clearly for local people.

The main concern is plans to remove Cheltenham Hospital's emergency and inpatient general surgery. 57 consultants and senior doctors at Cheltenham General Hospital have signed a letter stating the move could put patients at risk. Cheltenham General serves a population of at least 200,000 in Cheltenham, Tewkesbury borough and the North Cotswolds.

A cross-party campaign group called REACH (Restore Emergency at CGH Ltd) is opposing the change, and has invited trade unions and campaigners to join in common cause.

It's chaired by Michael Ratcliffe, who is also Chairman of the Cheltenham Chamber of Commerce. He said:

"There has been a serious failure of due process, lack of transparency and lack of consultation. Shifting all major emergency and elective general surgery to GRH would be a grave mistake, and is strongly opposed by many eminent doctors.

"This 'pilot' also appears to be a full-blown service delivery change in all but name. So we make no apology for fighting these proposals tooth and nail, on behalf of the people of Gloucestershire and surrounding counties."

"We make no apology for fighting these proposals tooth and nail, on behalf of the people of Gloucestershire and surrounding counties."

REACH argues that the Fit for the Future plan involves six steps to downgrade Cheltenham General:

1) Downgrade the Accident and Emergency Dept, which would then be replaced by an "Urgent Care Centre", manned by GPs and not hospital emergency specialists.

2) Transfer all emergency and major inpatient general/bowel surgery from Cheltenham General to Gloucestershire Royal, leaving intermediate and minor day-case surgery only.

3) Move all interventional radiology and vascular services to Gloucestershire Royal

4) Remove out of hours surgical cover for sick patients at Cheltenham's Oncology Centre.

5) Threaten the future of the pelvic cancer surgery unit at Cheltenham General

6) Isolate the medical gastroenterology unit, which was centralised in Cheltenham General Hospital two years ago.

NHS chiefs insist they do not recognise REACH's analysis.

The new campaign follows loud complaints by the local Tory MP in early August that the plans meant the town's A&E unit was to be downgraded, and a call by the Conservative group leader on Cheltenham Borough Council, for an emergency meeting for the full council to back the call for these proposals to be "dropped completely."

Local NHS bosses paused their "engagement" process for a fortnight in response to these claims, before relaunching its drive to win public acceptance of its plans to create "centres of excellence" … in Gloucester, 10 miles away.

Safe staffing: it's not just about nurses and doctors

What the (research) papers say

JOHN LISTER looks at three recent academic papers and a book relevant to NHS campaigners

John Lister

In the past five years numbers of nurses in England have risen by 4.6%: but the numbers of hospital admissions have risen by 12.3%. One in nine nursing posts are vacant. But if nurses are to be brought back in to the profession and new students attracted they must be given the hope of delivering a safe, effective service to patients.

Campaigns for improved nurse staffing levels in NHS hospitals, many of them modelled on similar campaigns in the US, Australia or less ambitious proposals that have become law in Wales and Scotland, all tend to refer with more or less precision to the proportion of patients to qualified nursing staff.

There is indeed a clear link established between higher levels of admissions per Registered Nurse and increased risk of death during an admission to hospital. These findings highlight the possible consequences of reduced nurse staffing: they point to the need to reject policies that encourage the use of nursing assistants to compensate for shortages of RNs.

Queensland Nurses and Midwives Union – now setting their sights on securing legal minimum staffing ratios for care of older patients.

Hospital management and ministers in England have been primarily seeking to avoid adopting any fixed nurse:patient ratio, even steering clear of the suggestion of a maximum of 8 patients per registered nurse set out in the Francis Report.

In 2013 a report from the National Quality Board and Chief Nursing Officer, '***How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability***', rejected defined staffing ratios in favour of the use of "evidence, evidence-based tools, professional judgement and a truly multiprofessional approach."

In October 2015, a letter from 'arms-length bodies' to Trusts attempted to clarify contradictory messaging between requirements to achieve safe staffing and "the need to intensify efforts to meet the financial challenge." It argued that the 1:8 ratio that NICE had highlighted as a potential alarm bell to trigger review of staffing levels, should be treated as a "guide not a requirement."

NICE was told to stop work on ratios – not least because a quarter of trusts responding to surveys reported that the 1:8 level was being exceeded (i.e. more than 8 patients per registered nurse) on more than 65% of shifts.

In England management and government preference, especially in the light of staff shortages, and the problems of recruitment, has been to substitute warm words for hard action, despite evidence in California that firm action to ensure the quality of care helps recruit and retain nursing staff. UNISON's report 2017 Ratios not Rationing explained clearly the positive impact it can have:

"In California, the number of actively licensed registered nurses increased by nearly 100,000 following the enactment of a staffing ratio law. Vacancies for registered nurses plummeted when the ratios were first implemented and turnover and vacancy rates have fallen far below the national average. There has also been a dramatic increase in the number of students interested in nursing as a career. These improvements show that ratios could be the answer to the current staffing crisis in the health service in the UK."

In Queensland the introduction of a mandatory ratio "has saved almost 150 lives and helped the government save millions of dollars."

The most substantial recent case study outside England also points to the need for a fixed maximum ratio of patients per nurse – and far fewer than 8:1. In Queensland the introduction of a mandatory ratio "has saved almost 150 lives and helped the government save millions of dollars."

The study, reported in *Nursing Times* looks at the actual impact of imposing a legal ratio of one nurse to four patients for morning and afternoon shifts, and one nurse to seven patients for night shifts for selected acute surgical and medical hospital wards and mental health units across 27 hospitals in Queensland since July 2016.

"They have also avoided 255 readmissions and 29,200 hospital days, with an estimated cost saving of between $55.2m to $83.4m (£30.7m to £46.5m). In addition, the average nurse on wards included has seen their workload reduce by one to two patients during the day, and one to three on a night shift.

"Reductions of one patient per nurse were associated with a 9% less chance of a patient dying in hospital, a 6% less chance of readmission within seven days, and a 3% reduction in length of stay."

These are important findings, and undermine the routine claims of staff shortages and added cost.

But there is also evidence of the advantage of a proper skill mix on wards, which can also save lives.

A paper published during the summer in the BMJ

Hospital management and ministers in England have been primarily seeking to avoid adopting any fixed nurse:patient ratio, even steering clear of the suggestion of a maximum of 8 patients per registered nurse set out in the Francis Report

Quality and Safety points out the need for adequate staffing levels of "nursing support" – which in England are normally Health Care Assistants – not as any kind of substitute for registered nurses, but as important additional support.

The US-based study developed a data set to allow researchers to measure staffing for each unit and each shift.

Its findings that additional support staff alongside registered staff helped improve patient outcomes raise the question of whether this is because when support staff numbers are low, registered nurses wind up doing more of the work they would do, "such as delivering and retrieving food trays, transporting patients, obtaining supplies and equipment and arranging transportation" to the detriment of patient care.

The study also suggests that while support staff are "not formally trained in patient assessment and monitoring, nonetheless contribute to these tasks as part of their contact with patients and through a developed ability to recognise patients who may need attention by others on the staff."

"When nursing support staff are less available, this contribution to the safety of patients is reduced."

The evidence is clear: we need sufficient qualified staff per patient, supported by sufficient support staff – HCAs, clerical, housekeeping and porters – to allow them to do their job. Without the full team the safety of patients can be jeopardised.

The campaign needs to be taken forward to learn these lessons and demand safe staffing on NHS wards.

Does integration of services work?

John Lister

"Integration" has been a word often abused and confusingly used by NHS England: but do any of the projects carried out in its name actually deliver on their promises?

A new research paper examining whether or not integration of health and social care services can deliver the promised result of reduced demand on emergency admissions comes up with a guarded positive reply.

This is potentially important, since as the study points out:

"Reducing emergency admission rates has been a feature of English health policy over the last decade and continues to be one of the most commonly used measures of success for system change initiatives. To date, however, there has been little evidence of initiatives successfully reducing emergency admissions."

But the periods studied were several years ago, and we are not told which areas are being studied. The researchers were examining policies brought in by "pioneer" projects in England: but their study compares performance from a "pre-pioneer baseline period (April 2010 to March 2013) over two follow-up periods: to 2014/2015 and to 2015/2016."

The findings could be very different after another three years of austerity funding of the NHS and cutbacks in local government and social care budgets.

It is also notable that the 'baseline' period from 2010 came at a very early point in the imposition of what has become a virtual freeze on real terms NHS funding, and was also prior to the implementation of the 2012 Health & Social Care Act, which established Clinical Commissioning Groups and NHS England. So two very different periods are being compared.

The overt allocation of existing resources to the pioneer projects was limited: "Each pioneer was given access to limited support and expertise over a 5-year period and a one-off fund of £90 000 to help with initial development."

However given the focus on such 'pioneer' projects it's likely that these projects were less subject to cutbacks, staffing shortages and funding pressures than services elsewhere.

I can't tell you how sorry I am...your husbands death is really going to bugger up our weekly performance figures!

The result was hardly dramatic: the pioneer areas managed to slightly limit the increase in emergency admissions

Even so the result was hardly dramatic. The pioneer areas managed to slightly limit the increase in emergency admissions: "we found a lower increase in emergency admissions for the pioneers than the non-pioneers".

Any such relief must be welcome, but the study points out a problem in generalising from this experience:

"…it is not possible to identify precisely which elements of the programme, if any, led to any differential change observed (since the pioneers were not working from an agreed template)"

The researchers also warn that:

"1. The effect appears to be temporary: and as such the effect may have been linked to changes that took place in the early stages of the pioneers or pre-pioneer but were not sustained; or the non-pioneer areas introduced changes which have subsequently reduced the difference between them and the pioneers.

"2. The changes in emergency admissions were not shown in all places and even varied between local authority areas within the same pioneer."

Are we any wiser? Perhaps it underlines the importance of service working closely together: if this can read across to the need to avoid fragmented contracts and privatisation, the lesson could be a useful one. We may have to wait a while for such conclusions.

Two-tier system with subsidised private sector

Beware the Irish model of healthcare!

John Lister

A recent research paper on private health expenditure and the affordability of private financing of health care in Ireland warns us that "reliance on private health expenditure as a funding mechanism undermines the fundamental goals of equity and appropriate access within the health care system."

Another research paper puts it even more bluntly:

"Ireland 'is the only Western European country that does not offer universal coverage of primary care, with 60% of the population paying out of pocket on average €52 per GP visit and two thirds of the population paying up to €144 per month for drugs as well as paying for other primary care services."

An emergency room visit without a GP referral is €100, a night in a hospital is €80 (up to an annual cap of €800) and even for those who sign up for the drugs payment scheme drug costs can be up to €144 per month.

Ireland had "the second highest rate of unmet need for healthcare due to cost, distance or waiting lists among EU countries in 2014," and the research shows an increasing incidence of "unaffordable private health spending" on user fees and private health insurance as patients seek to avoid long delays.

The origin of Ireland's two-tier system goes back to 1946. In Britain, Aneurin Bevan won his battle with the Tories and the BMA to push through the legislation to establish Britain's NHS: but in Ireland a popular but much less ambitious plan of free healthcare for mothers and children under 16 years was blocked by the power of the bishops and the conservative medical profession.

Eleven years later, as Irish journalist Maebh Ní Fhallúin recounts "the government established the VHI [voluntary health insurance] in its current form, a subsidised semi-state company that provided health insurance to those who could afford it. This policy decision resulted in the creation of a two-tier health system and remains in place today."

Impediment

VHI, covering 45% of the population and entrenching a 2-tier system, is now seen as a critical impediment to the implementation of a system of universal healthcare.

This is the hidden reality behind the Irish government's assurances that "Ireland has a comprehensive, government funded public healthcare system."

Ireland's Health Service Executive itself goes on to say that: "Over 30% of people in Ireland have medical cards. Medical Cards allow people to get a wide range of health services and medicines free of charge. … People without medical cards can still access a wide range of community and hospital health services, either free of charge or at reduced cost."

More accurately, researchers sum up:

"Ireland's two tier health care system means that although everyone can access the public health system, PHI [private health insurance] allows people to gain preferential access to elective care in both public and private hospitals and diagnostic tests. Ireland does not have universal coverage for primary care and access and associated charges for services in the public system are determined by an individual's circumstances."

The problem has been getting worse:

"During the period of the financial crisis many countries in the EU, including Ireland, shifted the burden of health care financing onto private sources. In Ireland nearly €500 million of the cost of some aspects of healthcare was transferred from the State onto people between 2008 and 2014. Consequently, the proportion of total funding coming from private health expenditure increased from 21% in 2008 to 30% by 2015."

This two tier arrangement, in which a massively under-funded public sector is combined with the VHI scheme that should serve as a warning for what could happen to our NHS

Irishisation threat to NHS

It is this two tier arrangement, in which a massively under-funded public sector is combined with the VHI scheme that should serve as a warning for what could happen to our NHS if current trends continue: it is the Irishisation of the NHS rather than Americanisation that seems a more likely threat.

As in the USA, Irish medical costs have been outpacing inflation – increasing six times faster – pushing up VHI premium payments by 6% this year. But at the same time public sector spending is being reined in, and the gaps in care and delays in treatment in the public hospitals are becoming a scandal.

The Irish Cancer Society has warned that cancer patients can face extra costs of up to €1,200 per month for drugs and hospital visits – "everything from chemotherapy appointments to anti-nausea medication and hospital parking charges."

University Hospital Limerick had a record 81 patients waiting on trolleys for emergency care in mid-September, and there are many signs the under-funded public system cannot cope.

As in Britain and elsewhere, the private sector largely avoids providing emergency or urgent care, which makes up most of the caseload of public hospitals; nor do private hospitals provide integrated rehabilitation for patients needing multi-disciplinary care.

So, as in England, "Most patients admitted as in-patients to public hospitals are not suitable for care in a private hospital, including most patients admitted via A&E. That is why there are patients with top level health insurance on trolleys in public A&E departments while there are beds empty in nearby private facilities."

The problem is that while up to 20% of Irish public sector hospital beds can at present be used for private patients, in practice far more are taken up, with up to 50% of all patients in public hospitals having private insurance.

Beds are in short supply, despite growing population: numbers fell during the financial crisis, and it's now estimated that up to 15,000 more acute beds are needed above the current 12,000. Public hospitals are running at 110% occupancy.

As in England, academics claim that an expansion

of nursing home places could relieve the pressure on hospitals, but this is not costed, and there is no plan to make this happen.

To make matters worse, ministers have given tax breaks for private hospitals which have encouraged a further growth in that sector – to the detriment of public hospitals, not least in the diversion of scarce specialist doctors. As the Irish Times pointed out back in 2003:

"This State encouragement of private medicine has been grafted on to a system in which private hospitals are primarily staffed by hospital consultants on public salaries. Of the 790 consultants staffing private hospitals and clinics in January, 75 per cent held public contracts."

Even though Fine Gael plans to switch to a Dutch-style insurance-based model were dropped on cost grounds in 2015, the contradictions of the two-tier system remain unresolved. It falls short of the access to universal health care which governments around the world in 2015 committed themselves to work for in the UN's Sustainable Development Goals (SDGs).

Tens of thousands of nurses, members of the Irish Nurses and Midwives Organisation INMO and the Psychiatric Nurses Union staged a series of strikes at the beginning of the year demanding increased pay and action to ensure safe staffing levels in crowded hospitals.

Sláintecare report

As a result in May 2017, an Irish cross-party parliamentary committee published proposals for ambitious reform, known as 'Sláintecare' – the first time there has been a cross-party political consensus on major health reform in Ireland.

But the consensus seems to have been short-lived. No minister was present at the end of August to launch a much delayed follow-up report. It was released with minimum publicity. It exposes institutionalised inequalities in access, funding and provision of care – and controversially proposes to remove private work from public hospitals within five years.

The income to hospitals for this work is estimated at €650m per year, and the proposal has triggered questions over the financial and practical implications of implementing the change, as well as predictable angry responses from some top medics, who are resisting any change to their contracts that might limit their private work.

One argued in Business Post: "The middle-class 'socialists' extolling a public-only system won't be seen for love or their insurance money in these hospitals. Public hospitals will become places where few will want to work. Hospital doctors, nurses and therapists are already shunning what were once highly sought-after positions in the public system for jobs in private hospitals."

Higher pay in private sector

Some of the doctors have plenty to lose. Many have been drawn to the much higher pay in the private sector: doctors working full-time in the private sector can expect to earn anywhere from €280,000 to €1 million: by contrast those in the public system hired since 2012 are typically paid between €112,000 (if they are allowed to work off-site) and a maximum of €165,000 (public-only work).

Cancer campaigners in 2015 highlighting costs of treatment

The Sláintecare reforms could increase this to €182,000, but still fall short of private sector levels.

But the problems aren't restricted to the hospital sector; there has also been a process of corporatisation of primary care through the injection of private capital into the development of primary care centres (PCCs), and private firms' increasing influence over general practice through partnerships with doctors.

About 55 per cent of Ireland's PCC premises are leased by the HSE from private landlords, and 10 per cent are (PFI-style) PPP projects: just 35 per cent of them remain in public ownership. American, Australian and British capital is involved in this market as well as Irish companies.

A recent overview in Business Post notes that:

"Critics of corporate ownership in general practice say it drives up referral rates, lengthens waiting lists, reduces investment in the practice, breaks continuity of care and erodes accountability by diminishing GPs' control."

While the future of Irish healthcare, and the commitment of the government to its own reforms remain uncertain, the harsh inequalities, financial costs and gaps in the Republic's flawed two-tier health system continue.

They are one reason why the voting public in Northern Ireland might fear growing links with the Republic – as well as a stark warning as to what could become of England's NHS if the chronic under-funding is not reversed.

The report exposes inequalities in access, funding and provision of care – and controversially proposes to remove private work from public hospitals within five years.

As another winter approaches …

What's happening to our A&Es?

As autumn sets in and winter looms there are already worrying signs of another year's winter pressures on the NHS, and a reminder of the extent of the decline that has taken place since 2010. JOHN LISTER reports.

NHS England figures show a staggering increase of 1,400% in the numbers of so-called "trolley waits" from August 2010 to August 2019.

Other NHS figures show 12 hour waits for a bed after a decision to admit a patient have increased 372-fold from just 1 in August 2010 to 372 in April 2019

Perhaps even more alarming is the big increase in pressure on emergency services across the summer months which used to be relatively quiet.

In July 2019 there were 57,694 patients waiting more than 4 hours from decision to admit to admission, 34.7% higher than July 2018. Of these, 436 patients waited more than 12 hours (192.6% higher than in July last year).

More shocking perhaps is that the increased delays flow from a combination of rising use of A&E with a hefty reduction in front-line beds and services outside hospital. Numbers of the most serious "Type 1" emergency patients attending A&E in August have increased by just 21% since 2010, while the population is estimated to have increased by around 5.6%.

More seriously ill

However the patients who arrive are more likely to be seriously ill and require a bed: numbers of Type 1 being admitted have increased by more than a third (34%) over the same period, with the proportion of patients being admitted increased from 25% to 30%.

Total emergency admissions to hospital, which include urgent referrals by GPs, have risen by 28%, and by a significantly higher rate than general attendances at A&E.

But while the numbers have been rising on all fronts, the numbers of front-line beds available to admit them to has been falling overall: there were 8,779 fewer "general and acute" beds available in quarter 1 of 2019-20 than there were in quarter 1 of 2010-11. The reduction of almost 8% has come from a system that for years has had fewer hospital beds per head of population that almost any comparable country.

But there has been an even sharper reduction in mental health bed numbers: back in April 2010 there were 23,515 mental health beds: by April 2019 there were just 18,271 – a reduction of over 5,000 beds, or 22%. The targets for mental health are all much less demanding than those for acute hospital care, but NHS Improvement notes that at the end of June 2019 there were 805 Out of Area Placements for mental health patients, of which 770 (96%) were "inappropriate" (resulting from a lack of local NHS beds available).

The squeeze on acute hospital beds has run alongside a chronic failure to hit performance targets for emergency care and elective treatment.

NHS Providers last month noted that while the government's target is to admit 95% of patients within four hours, A&E performance had been "sitting around the current 86.5% for the last 3 months:" the 95% target has not been achieved for four years.

NHS figures show 12 hour waits for a bed after a decision to admit a patient have increased 372-fold from just ONE in August 2010 to 372 in April 2019

4.5 million on waiting lists

The BMA notes that there are now 4.52 million people in England now waiting for treatment, with 14.2% waiting over 18 weeks.

NHS Providers also pointed out that the NHS is "missing the three key cancer targets – the 2 week wait, 31 day and 62 day."

The decline in performance in cancer care has been especially notable, since figures were first collected in 2016. Then 94.8% of suspected cancer patients were seeing a consultant within 2 weeks of an urgent referral by a GP: now just 90.9% are doing so, bringing anxious delays to 180,000 people last year.

The performance on urgent referrals for patients with breast symptoms but not initially suspected as cancer has plummeted from 96.1% seen within 2 weeks to 82.4% in July.

In June the Public Accounts Committee heard that one in five cancer patients is having to wait up to two months to begin hospital treatment.

July was the 43rd consecutive month that the government target - to treat 85% within two months - has been missed. More than two thirds (69.9%) of providers missed the target.

As the BMA has warned, these figures indicate more trouble looming as the temperatures drop:

"Given the lack of a recovery from winter, it looks likely that the upcoming winter will see unprecedented pressure on the NHS.

"This will result in longer waits, with staff and patients suffering the consequences unless the Government takes action."