THE lowdown

Health news, analysis and campaigns.
NUMBER 29, July 20 2020

Informing, alerting and empowering NHS staff and campaigners

Bed figures show NHS has bounced back already

John Lister

NHS trusts have succeeded in restoring in-patient activity to pre-Covid levels, with A&E attendances and emergency admissions lagging only slightly behind according to the latest figures published by NHS England.

The July 5 COVID-19 daily situation report shows almost **92,000** NHS beds occupied in England, including 2,088 occupied by patients with confirmed COVID-19. This is slightly **HIGHER** than the average of just over 90,000 general and acute beds occupied in the three months January to March 2020 – before the pandemic struck, and including the peak winter months of January and February, with an occupancy rate of 88%.

If correct, these latest figures show that the 37,000 beds emptied in March and early April to create capacity to tackle the Covid pandemic have largely reopened, and that hospital trusts have been far faster at restarting elective services than has been reported.

And it seems the numbers are valid: NHS Providers' director of policy and strategy Miriam Deakin told the *Lowdown* that their analysts could not find any reason to question the figures.

"The NHS was very successful in responding to the surge in pressures when COVID-19 took hold," she added. "The high level of bed occupancy shows how hard the service has worked to restart a fuller range of services after the first peak."

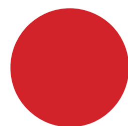
A&E caseload up again

June figures for attendances and emergency admission at A&E departments also show a significant bounce back from the lowest point during the pandemic. There were just over 1 million attendances at major A&E departments in June, down 24% on June 2019, compared to 42% in May – while Type 1 emergency admissions in June were just 15% down on the same month last year.

The unsung success story of the NHS coping and reorganising services through the extraordinary efforts of front line staff has been partly obscured by publicity for heart-rending cases where patients have suffered or had their lives shortened by delays in accessing diagnostic tests, outpatients , elective or emergency treatment. Some outpatient clinics have seen an 80% reduction in numbers attending and urgent cancer referrals in April were down by an average of 60%.

Hospital corridors are still empty, but the beds are filling up

Publicity highlighting the large-scale reduction in A&E attendance, the suspension of many elective services and outpatients, and the soaring waiting list have not been followed up by equivalent focus on the efforts that have been made to get services back on track.



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Winter warning

But with winter and a possible flu epidemic still to come, NHS Providers' Miriam Deakin warns:

"There are still serious concerns about having the capacity to deal with the challenges in the months ahead. These include working to restore routine services against a background of pent up demand which is starting to feed through.

"We welcomed the additional funding announced last week, including confirmation trusts can continue to access capacity in nightingales and in the independent sector until March but it's unclear whether this will be enough to cope with what lies ahead.

"And it's important to look beyond hospital bed capacity to consider growing demand for mental health, the need to strengthen community rehabilitation services and to shore up NHS 111.

"Finally there's the concern for staff, many of them exhausted and some traumatised by the events of recent months."

The bounce back to full wards and busy A&Es also raises doubts on how the NHS will cope with the widely expected second surge of Covid. Will any tangible steps be taken to address staff shortages? Watch this space.

IN THIS EXPANDED SUMMER HOLIDAY ISSUE

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Sussex mega-trust foments fears of cuts

A large swathe of Sussex is to see its NHS hospital trusts merge into one mega-trust with a turnover of more than £1 billion a year.

Brighton and Sussex University Hospitals Trust (BSUH) with around 8,000 staff and an annual income of almost £600 million a year, will merge with Western Sussex Hospitals with more than 7,000 staff and an annual income of almost £500 million.

The new organisation would serve Brighton and Hove, Mid Sussex and the coastal stretch of West Sussex from Shoreham to Chichester. This includes St Richard's Hospital, Chichester, Worthing Hospital, Southlands Hospital, in Shoreham, the Royal Sussex, the General Hospital, Royal Alexandra Children's Hospital and Sussex Eye Hospital, all in Brighton, and the Princess Royal Hospital, in Haywards Heath. With a possible 15,000 staff, the trust would be dominant along the south coast, overshadowing much smaller neighbouring trusts.

Concerned

Campaigners in Sussex fear the merger could have negative implications for staff and patients and a knock-on effect on hospitals in the east of the county in Eastbourne and Hastings.

They speculate that staff numbers will be cut and the centralisation of services will create access problems for patients. The campaigners point to difficulties of access for patients if the rumoured-merger of the Brighton Eye Hospital with the eye unit in Worthing goes ahead.

Madeleine Dickens of Sussex Defend the NHS said: "The announced merger of Western Sussex Hospitals NHS Foundation Trust and BSUHT in Brighton is just the first step in the imposition of the West and East Sussex Sustainability and Transformation Plan, first announced in 2016.

"We fear that long-rumoured closures and downgradings of hospital services will follow on from this. The closure of the BSUHT Eye hospital with the transfer of provision to Worthing hospital and futures of the Queen Victoria in Lewes, Eastbourne DGH and the Princess Royal in Haywards Heath could all be in question."

Announcement

The merger decision was announced to staff in a letter sent 6 July, in which, Dame Marianne said the trusts had decided they needed to revisit the options "in the light of the changes in the NHS and the recent successful joint working between the trusts".

The statement also said: "Our ambition with a new, single organisation is to create new specialist services and continue to develop and deliver outstanding local care to our patients….Building on this closer working relationship and creating a new, single organisation will provide us with many opportunities to design and grow services for our local communities and improve the care we provide across Sussex."

This merger was first proposed back in 2016, after BSUH was placed in "financial special measures" due to its large deficit and a Care Quality Commission (CQC) rating of "inadequate". Western Sussex at the time was rated "outstanding" by the CQC.

Campaigners in Sussex fear the merger could have negative implications for staff and patients and a knock-on effect on hospitals in the east of the county in Eastbourne and Hastings.

In April 2017, the chief executive of Western Sussex, Dame Marianne Griffiths, took control of both trusts and the plan was for the Western Sussex to help BSUH improve.

In a CQC inspection in 2019 Western Sussex retained its "outstanding" rating, whilst BSUH improved its rating to "good". BSUH left quality special measures in January 2019 and financial special measures in July 2018.

However, despite the input from Western Sussex, in August 2019, NHS Improvement raised concerns over BSUH's financial and waiting time performance and warned it could take formal action.

In October 2019 the working together was formalised and the two trusts formed a permanent group structure with shared leadership. As well as sharing a chief executive, they now also share several executives and a chair, Alan McCarthy.

Action

Madeleine Dickens believes "the implications are dire" and will prove controversial and is taking part in a regional network to fight the plans along with members from the seven other NHS campaigns across the two counties.

The trusts themselves still have to develop a full business case for the merger.

There are also implications for neighbouring trusts; in January 2020, the tiny Queen Victoria Hospital Foundation Trust, in East Grinstead, indicated it could join any group structure, but now it will have to consider its plans in the light of the full merger.

HSJ reports that the governors of both trusts support the proposed merger.

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CCGs caught short-changing mental health services

Several Clinical Commissioning Groups (CCGs) have been found to have made false claims about how much they have spent on mental health services in the 2018/19 financial year, according to the HSJ.

The information from NHS England and NHS Improvement, seen by the *HSJ*, shows that in the 2018/19 funding period auditors found that 16 CCGs had falsely claimed that they had spent sufficient on mental health services in their areas and met the targets set under the Mental Health Investment Standard (MHIS).

The MHIS was put in place in 2015, following years of mental health service funding dragging a long way behind that of physical health services. The MHIS is the requirement for CCGs to increase investment in mental health services in line with their overall increase in allocation each year.

The shifty sixteen

HSJ revealed the 16 CCGs as: Brighton and Hove, East Sussex, Milton Keynes, Ashford (now Kent and Medway), Canterbury and Coastal (now Kent and Medway), Thanet (now Kent and Medway), North East Hampshire and Farnham, North Hampshire, Hastings and Rother (now East Sussex), Gloucestershire, Mansfield and Ashford (Now Nottingham and Nottinghamshire), Nottingham North and East (now Nottingham and Nottinghamshire), Salford, and Trafford.

These 16 CCGs will have published a statement at the end of the financial year in which they stated that the CCG had followed the planning guidance in 2018/19 and achieved the MHIS. However, the independent audits that are carried out on the CCGs found that these were false claims.

Letters have been sent to the CCGs by NHSE/I national mental health director Claire Murdoch and finance director for NHS England and Improvement Julian Kelly, according to the *HSJ*, which stated that NHSE/I was "disappointed to see that the independent review by reporting accountants found that you had not in fact met the standard."

NHS England reports that since it was introduced in 2015, the MHIS has been met nationally.

Ten years of restraint

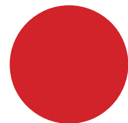
This may be the case, but looking at the reality of mental health service provision in England, it appears to have had little impact against the effect of ten years of budgetary restraints and increased need.

At the end of 2019 and the start of 2020 there was a flurry of reports on the escalating crisis in mental health services, in particular in Child and Young Adult Mental Health Services (CAMHS).

These showed that tighter restrictions on access to mental health services have been introduced and as a result thousands of young patients are being denied care, which in turn has led to a large rise in the numbers turning up in A&E and patients being directed to private care.

Staff and bed numbers have fallen and infrastructure is poor and in dire need of renovation. In 2013 there was one mental health doctor for every 186 patients accessing services, and one mental health nurse for every 29 patients.

By 2018 those figures had dropped to one for every 253, and one for every 39, respectively.



A Royal College of Psychiatry report argues that, to offer appropriate levels of care to patients in their local community, more than 1,000 extra mental inpatient beds are needed

Extra beds

In November 2019 the Royal College of Psychiatry (RCP) published a report claiming that, to offer appropriate levels of care to patients in their local community, more than a thousand extra mental inpatient beds were needed.

The evidence is clear that the MHIS has had little impact on mental health services and they have continued to deteriorate.

In January 2019, the NHS's Long Term Plan contained another commitment to increasing funding for mental health care; from 2019/20 onwards the MHIS also includes a commitment that local funding for mental health will grow by an additional percentage increment to reflect additional mental health funding being made available to CCGs.

More recently the government has given £5 million to tackle the massive requirement for more mental health services due to the Covid-19 pandemic.

It remains to be seen whether this is sufficient to pull mental health services out of a crisis.

We're taking a break

It's that time of year when many people take a well-earned break, and we at the Lowdown reckon we deserve one too.

We will not be publishing in August as we take two issues off.

But if you want to make sure we can resume and sustain and improve the Lowdown into a third year, please *make a donation* to help us recruit and employ the staff we need to keep it going .

South West London hospital plan referred to Matt Hancock

John Lister

Merton Council has decided to refer the proposal to build a new hospital in Sutton and downgrade and downsize both Epsom and St Helier hospitals to the Secretary of State, Matt Hancock.

The controversial plans and a skimpy "Decision Making Business Case" were rubber stamped on July 3 after perfunctory discussion at a Committees in Common meeting of South West London and Surrey Heartlands CCGs.

Merton council sums up its objection as threefold, arguing:

"the CCG's consultation on the IHT has been inadequate in relation to content or time allowed,

"the context of the increased demands on NHS resources as a result of the COV19 pandemic (and potential future pandemics),

"and … the Council considers that the proposed decision would not be in the interests of the health service in its area."

The council includes in the reference back its own document criticising the "Improving Healthcare Together" plan, and responses from Siobhain McDonagh MP, Community Action Sutton, Merton Voluntary Services, Sutton council, Dr Rosena Allin-Khan MP for Tooting (covering St Georges Hospital), Epsom and St Helier Unison branch, Merton & Sutton Trades Council, GMB union, and local campaigners (KOSH and KOEH).

Acute bed numbers slashed

Indeed the £500m plan that would effectively halve the number of available acute beds to cover a population of 770,000, and concentrate all acute beds and consultants on the Sutton site, has not only failed to win support from either of the London boroughs directly affected by the plan, but also been opposed by Epsom Tory MP and former minister Chris Grayling.

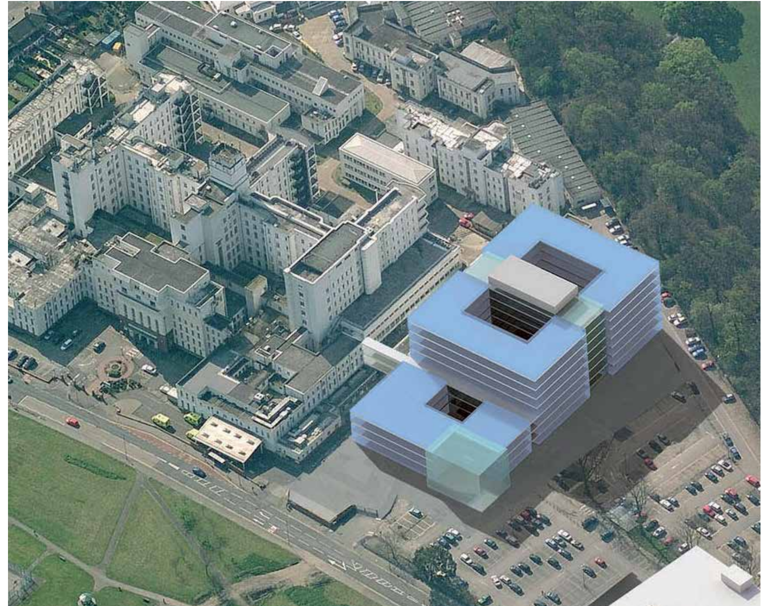
Perhaps surprisingly Grayling's letter, centred on redirecting the available investment to Epsom Hospital, and ignoring any wider issues, makes some valuable points.

He notes that "the public consultation did not give a clear mandate to build at Sutton, and the analysis of it only showed a marginal preference following a pretty intense campaign by the NHS leadership to sell its preference."

Grayling also argues that "there is now not sufficient funding available to guarantee that the project can go ahead at Sutton. … The expectation in the construction industry today is that costs will rise by as much as 20% following the pandemic."

And he echoes the unions in noting that "Unless a fully workable vaccine is found for the virus, some degree of social distancing will remain necessary for the time being and this must be factored into the projected costings."

However the attempt by Merton and Sutton TUC to draw a response to the IHT plan from the Independent Chair of South West London's so-called "Integrated Care System" has underlined the hollow claims of the ICS.



So near and yet so far: architects' image of new St Helier hospital, funded 2009, only to be abandoned in post 2010 austerity

The £500m plan would effectively halve the number of available acute beds to cover a population of 770,000, and concentrate all acute beds and consultants on the Sutton site

The letter than eventually came back to TUC Secretary Kevin O'Brien stresses that for all the talk of integration and coordination, the ICS (the South West London Health and Care Partnership) "is not a statutory organisation" and that responding to the proposals is a role only for statutory bodies (CCGs).

Old arguments

Rather than respond to the points on behalf of the ICS, the Independent Chair, Millie Banerjee, apparently delegated the CCG's senior responsible officer Sarah Blow to produce a 3-page letter which rehearses the stale old arguments for the Sutton Hospital.

The letter is principally remarkable for completely ignoring the concerns raised and the opposition to the scheme by both of the London boroughs – which are allegedly "partners" in the SW London ICS.

Ms Blow also managed to craft a reply that ignored specific questions from the Trades Council about the conflict between the IHT plan to slash numbers of front line acute beds and the explicit guidance to the contrary from NHS England in January, followed by more recent guidance in the light of the Covid pandemic from NHS England Estates director Simon Corben.

Perhaps even more remarkably the letter makes no mention at all of the pressures and problems to be faced by the NHS in the post-Covid situation.

Ms Blow uses weasel words to dodge around the TUC's argument that locating a new acute hospital in Sutton would inevitably increase the numbers of patients referred to it from the Royal Marsden's Sutton site next door, which has no operating theatres – arguing only that "there are no plans to use the acute beds … for private patients from the Royal Marsden."

The CCG, which now incorporates Merton and Sutton CCGs which have driven the IHT plan with the leaders of the Epsom & St Helier Trust, might feel able to duck and dive, but the referral of the plan to the Independent Reconfiguration Panel (IRP) could bring a more sober overview.

As Merton council's letter to Hancock says:

"The Council is confident that the IRP would conduct a proper analysis of the merits of the proposal and will see the obvious flaws in the approach taken by the CCGs."

Please support campaigning journalism, to help secure the future of our NHS

Dear Reader
Thank you for your support, we really appreciate it at such a difficult time.

Before Covid 19 the NHS was already under huge pressure and, after it's all over there will be a backlog of patients, queues of people affected by the crisis, and a hugely tired workforce.

From that moment we will need a much more credible plan to fund, support and protect our brilliant NHS. Our goal is to help make this happen and we need your help.

We are researchers, journalists and campaigners and we launched ***The Lowdown*** to investigate policy decisions, challenge politicians and alert the public to what's happening to their NHS.

It is clear from the failures of recent years that we can't always rely on our leaders to take the right action or to be honest with us, so it is crucial to get to the truth and to get the public involved.

If you can, please help us to investigate, publicise and campaign around the crucial issues that will decide the future of our NHS, by making a donation today.

Our supporters have already helped us to research and expose:

- **unsafe staffing levels** across the country, the closure of NHS units and cuts in beds
- **shocking disrepair** in many hospitals and a social care system that needs urgent action, not yet more delays
- **privatisation in the NHS** - we track contracts and collect evidence about failures of private companies running NHS services.

First we must escape the Covid crisis and help our incredible NHS staff.

We are helping by reporting the facts around the lack of protective equipment for hospital staff but also for thousands of carers.

We are publishing evidence about more community testing and the shortcomings in our strategy to beat the virus.

Even though they have a tough job, there have been crucial failings: on testing, PPE and strategy and we must hold our politicians and challenge them to do better.

We rely on your support to carry out our investigations and get to the evidence. If you can, please make a regular donation, just a few pounds a month will help us keep working on behalf of the public and NHS staff - thank you.

We all feel such huge gratitude and respect for the commitment of NHS staff and it's so impressive to see such strong public support. Let's hope that we can give the NHS the thanks it deserves and crucially, secure its future.

With thanks and best wishes
from the team at the *Lowdown*

Every donation counts!

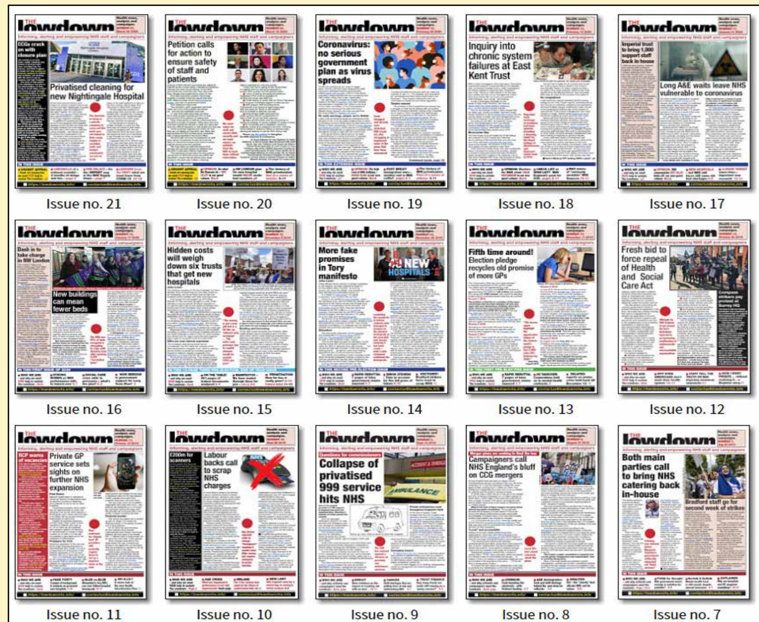
We know many readers are willing to make a contribution, but have not yet done so.

With many of the committees and meetings that might have voted us a donation now suspended because of the coronavirus, we are now asking those who can to give as much as you can afford.

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

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

● Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG



● If you have any other queries or suggestions for stories we should be covering, contact us at *contactus@lowdownnhs.info*

Will they or won't they?

Is Johnson pondering NHS power grab?

John Lister

The *Guardian* July 10 report suggesting Boris Johnson is planning a "radical shake-up of NHS in a bid to regain more direct control" has understandably triggered alarm in many campaigners, but also confusion on a number of levels.

A subsequent HSJ report largely contradicts the *Guardian* account, suggesting that the proposal for legislation originates not from Downing Street but from Health Secretary Matt Hancock – and that Downing Street has halted moves to push through legislation this summer and pushed it back to 2021, fearing the imminent possibility of a second peak of Covid-19 infection and a grim winter ahead.

The alarm at the *Guardian* version of events centres on the likely consequences of an intervention by a government that is clearly led by Dominic Cummings, Johnson's principal advisor, especially when the task force that the *Guardian* reports has been established to draw up proposals for legislation includes Cummings' and Johnson's controversial health advisor William Warr.

Warr is an avid proponent of apps and digital solutions, an opponent of extra funding for the NHS, and an advocate of focusing "public health" initiatives towards younger people – as long as these do not include "sin taxes" on sugar, alcohol etc. – while dismissing the increasing numbers and health needs of older people as a major pressure on the NHS.

The Johnson government's response to the coronavirus and Covid-19 has been a refusal to engage with existing public sector expertise or resource public sector providers, coupled with a turn to private sector consultancies and contractors including hundreds of millions of pounds awarded in no-bid contracts for supplies of PPE to small and completely inappropriate companies.

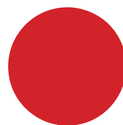
Private sector

Many campaigners fear that the same government gaining increased direct control over the NHS will lead to further rapid increases in the share of NHS spending flowing out to private companies.

The *Guardian* report does not mention more privatisation, but focuses on the arm's length separation between the government (Department of Health and Social Care) and NHS England, whose chief executive Sir Simon Stevens is not directly accountable to Matt Hancock. This separation was established in law by the controversial 2012 Health and Social Care Act driven through by David Cameron's government with key support from its Liberal Democrat coalition partners.

Now the *Guardian* suggests the task force is aiming to reverse this legislation, and "drawing up proposals that would restrict NHS England's operational independence and the freedom Stevens has to run the service."

NHS treats the patients: government and contractors have screwed up PPE procurement, testing and tracing contacts



Many campaigners fear that this government gaining increased direct control over the NHS will lead to further rapid increases in the share of NHS spending flowing out to private companies

However no tangible reason is given for this power-grab from the centre. The *Guardian* article quotes "a source with knowledge of the plans" as saying "[The health secretary] Matt Hancock is frustrated [by] how limited his powers are and wants to get some of that back."

However there seems to be no rational explanation for this sudden change of line, or what powers Hancock/Johnson/Cummings are seeking to reclaim.

Under-funding

The issues that appear to be frustrating ministers and the Treasury ("The Treasury in particular is irritated that NHS treatment waiting times continue to worsen, and many hospitals remain unable to balance their budgets, despite the service receiving record funding") are the result of a decade of deliberate under-funding and under-resourcing that had left the NHS short of beds and up to 100,000 staff, and almost doubled the size of the waiting list from 2.5 million in 2010 to 4.4 million at the end of 2019.

Other problems – the chaotic, largely privatised, test and trace system and shortages of PPE – are a consequence of the Johnson government's own political intervention. Indeed as ministers have brought in consultants from McKinsey to try to sort out the shambolic test and trace system, the *HSJ* points out that it is not run by NHS England, but by Matt Hancock's own DHSC:

"McKinsey has been asked to explore the status and future shape of the organisation, potentially considering whether it should remain as a directly controlled DHSC agency; be given greater operational independence; or be merged into another DHSC

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arms-length body, such as Public Health England."

In other words the government is already in charge – and to blame for the shambles – now.

Other changes which the *Guardian* cites as reasons for the Johnson power-grab are already being eagerly promoted by NHS England – and central to last year's Long Term Plan.

Changes

These include minsters' "desire to make permanent some recent changes in NHS working, such as different NHS bodies working closely together, and the huge increase in patients seeing their GP or hospital specialist by video or telephone", and turning "integrated care systems, which are currently voluntary groupings of NHS organisations within an area of England, into legal entities with annual budgets of billions of pounds and responsibility for tackling staff shortages and ensuring that the finances of its care providers do not go into the red."

The reported Tory determination to "clip the wings" of Simon Stevens also lacks any obvious explanation. Stevens, not least because of his past record as an advisor of marketising reforms to Tony Blair in the early 2000s and subsequently an Executive Vice President of US health giant UnitedHealth, is seen by many on the left as a leading force driving privatisation.

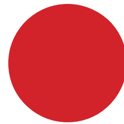
For that reason the same campaigners have criticised almost any proposal Stevens has made, including last year when he and NHS England pushed for legislative changes that would unpick some of the 2012 Act, most notably removing the requirement to open increasing numbers of services up to competitive tender, and clearing the obstacles to integrated care systems that bring together commissioners and providers.

For Stevens now to become a target of hostility from the right wing Johnson government conflicts with this view, and the only explanation for the current stand-off between him and Matt Hancock seems to be Stevens' willingness in the past to speak out, notably to the Commons Health Committee, against under-funding of the NHS.

Loggerheads

Early in 2017, for example he was reportedly at loggerheads with Theresa May for sounding the alarm over health funding and over his handling of the A&E winter crisis.

Also linked to waiting times, Stevens and NHS



Ministers have brought in consultants from McKinsey to try to sort out the shambolic test and trace system,but it is not run by NHS England: Matt Hancock's own DHSC is in charge

England appear to have clashed more recently with the Treasury – over their proposal to block book thousands of private hospital beds through to next spring at a cost of £5 billion, as a means to reduce the growing waiting list while not fully reopening thousands of NHS beds.

So with or without the involvement of Stevens, are some campaigners right to believe that the Johnson government's proposed changes are in fact aimed at securing changes similar to the ones people fighting to reverse the 2012 Act seek to achieve?

Curbing the powers of NHS England and increasing the health secretary's 'powers of direction' over it, "so that [Hancock] doesn't have to try to persuade Simon Stevens to do something," may seem similar to the demand of proponents of the NHS Reinstatement Bill to re-establish government accountability for the NHS by putting the Secretary of State back in charge.

Without seeing any of the task force's proposals we can't be sure what will be said or what it means in practice. But in 2020 Britain it's arguable that the real power does not flow through parliament and is not held by the secretary of state, an elected MP, but is in the hands of the unelected Dominic Cummings.

Silencing critical voices

Only the terminally naïve can really believe it likely that the current centralising government so ruthlessly attempting to silence critical voices would combine the restoration of the powers of the secretary of state with extending local accountability of services that campaigners have been demanding.

The *Guardian* also suggests the government might bring forward legislation to abolish the foundation trust status introduced by Tony Blair in 2004, and a central plank of the 2012 Act "as part of a drive to give the DHSC more control over the day-to-day running of the health service."

Campaigners fought a long campaign attempting to block the establishment of foundation hospitals, arguing that they would be even less accountable than NHS trusts to local people.

However foundation trust status and "freedoms" have now become largely academic in a hugely under-funded NHS burdened with hefty deficits: NHS England's edicts and plans for integrated care systems largely

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Is Johnson planning an NHS power grab?

continued from page 7

ignore any distinction between NHS and foundation trusts.

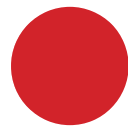
More top-down DHSC control over foundation trusts would not satisfy the demands of campaigners: but it would put the government fairly and squarely in the firing line and visibly carrying the can for any failures and gaps in services. The 2012 Act gave ministers a way to duck responsibility, and blame local commissioners of providers – and NHS England – when things go wrong.

The King's Fund and others have warned that for Cummings and Johnson to reverse that separation now, at a time of unparalleled crisis, with no sign that Chancellor Rishi Sunak is willing to give the NHS the extra funding it will need to go forward and restore elective and emergency services while retaining capacity to cope with continued Covid-19 cases, would be a massive own goal.

Hunt response

Former Health Secretary Jeremy Hunt has already urged Johnson to drop plans for a major reorganisation of the NHS, which suggests the proposals could face a rough ride even amongst the Tory ranks. Hunt told the *Independent* he believed the 2012 Act was one of David Cameron's "biggest regrets":

"I would be astonished if Boris wanted to do the same. If you want to improve care for patients, then looking at the quality and safety of care is going to have far more impact than another big reorganisation," he said.



The whole idea of a major restructuring of the NHS could be little more than a Cummings-style "dead cat" thrown onto the table in an effort to distract attention from the government's chaotic performance

At the last election just 8 months ago , the Labour Party and Green Party both pledged to repeal the 2012 H&SC Act and so end competitive tendering and privatisation across the NHS, and Labour promised that all integration of care will be delivered via public bodies. The Conservative manifesto pledged to continue with the restructuring set out in the Long-Term Plan: and the Notes to the new government's Queen's Speech stated that:

"The Government is considering the NHS's recommendations thoroughly and will bring forward detailed proposals shortly.

"This will include measures to tackle barriers the NHS has told Government it faces. This will lead to draft legislation that will accelerate the Long Term Plan for the NHS, transforming patient care and future-proofing our NHS."

Nobody would be surprised to see the Johnson government, with its 79-MP majority, discard such recent promises and seek to clip the wings of Stevens: but it should be obvious that opposition parties have nothing to gain from endorsing their approach.

We should also be aware it's more than possible that the whole idea of a vague and inexplicable major restructuring of the NHS could be little more than a Cummings-style "dead cat" thrown onto the table in an effort to distract attention from the government's chaotic performance on test and trace, the hundreds of millions wasted in ridiculous PPE contracts, and the massive, rising toll of excess deaths since the Covid pandemic first struck.

Manchester protest at privatisation of fertility services

Vivien Walsh (Greater Manchester SHA)

On July 4th, the day before the 72nd anniversary of the founding of the NHS – we demonstrated (with PPE and social distancing), jointly with Manchester Trade Union Council, with UNISON, Unite and other unions, Keep Our NHS Public and with Health Campaigns Together against the privatisation of fertility services at St Mary's Hospital, Manchester.

The service, provided by the Department of Reproductive Medicine (DRM) at St Mary's, faces privatisation. According to reports, Manchester Foundation Trust announced earlier this year that they cannot afford to fund a £10m upgrade of the internationally renowned unit, and want to close the department.

The fertility service would go over to a private company in 2021. This would be a disaster for the service and future patients. Now the Trust has begun an "options appraisal" over the future of the service. We insist that the #1 option must be keeping it public and keeping it where it is. We demand a public consultation so the people of Manchester have their say.

Women in the labour movement have been campaigning for at least 100 years on issues of maternal health and the right to choose whether and when to have children, and to use any technological advances that might make those choices easier, or even possible.

That's why unions and campaigners are fighting so hard to defend the services that have been won over many years.

Speakers from UNISON, Unite, KONP and SHA joined a July 20 public meeting via Greater Manchester Keep Our NHS Public (GM KONP)'s Facebook page demanding 'No privatisation of Manchester's fertility service'.

For more information, see the article on the Socialist Health Association website which spells out in more detail how DRM is unique and why it is imperative that it remain at St Mary's and within the NHS.

CQC calls for intervention at failing trust

John Lister

The now notorious Shrewsbury and Telford Hospitals Trust, which is facing more criminal investigations and enforcement actions than any other trust in England, has been heavily criticised again in a letter from the chief inspector of hospitals leaked to the Independent.

The last CQC inspection report in January found the trust to be "inadequate" overall and on fur of the five specific criteria, with a "requires improvement" rating for "are services caring".

Trust bosses have had 90 specific conditions imposed in five CQC inspections since 2018, but as Professor Ted Baker's latest letter, demanding an urgent meeting with NHS England to discuss the next steps, reveals they have failed to change a management culture which has led to "a lack of professional accountability and professional curiosity amongst staff to recognise, challenge and address poor care."

Toxic

So toxic is the system that even with far more generous than average staffing levels services continue to raise "significant safety concerns".

"This culture and underpinning normalisation of poor care is the environment in which future health

professionals are being trained. We are concerned that unless this is addressed at pace by a sufficiently capable team, this will be compounded by those providing care to patients [at the trust] in the future not knowing what good truly looks like."

A year ago the trust's Chief Executive Simon Wright announced he was stepping down. According to the trust he was to "take up a role working with sustainability and transformation partnerships", although this was quickly thrown into doubt.

His replacement Paula Clarke was acting chief until February, when the trust's current chief executive Louise Barnett joined the hospital – but it seems that the underlying problems have not been tackled.

A frustrated Prof Baker says frontline staff have reported "lack of visibility and diminishing confidence in the executive leadership team's ability to acknowledge and address any concerns raised. This has been a consistent theme throughout our inspections."

investigations

Now 1,900 cases of alleged poor care at the trust going back decades are being investigated.

To make matters worse the trust is in the process of driving through a controversial reconfiguration that will strip emergency services and specialist services from Telford Hospital to "centralise" in Shrewsbury, which has risen in projected cost from £312m to £498m.

Before the first bricks are laid, the trust could be taken over by a Trust Special Administrator, a process which culminated in a major report in December 2013 that broke up the Mid Staffordshire Hospitals Trust, and moved services to Stoke and Wolverhampton. For the sparsely scattered population of Shropshire any similar result could be yet another disaster after a decade of sub-standard care.

CSU bosses speed up plans for job cuts

John Lister

Over 200 jobs are at risk in a massive reorganisation of a major Commissioning Support Unit that delivers services for CCGs in parts of London, surrounding areas and eastern England.

Staff at NEL CSU fear that the first redundancy notices could be issued in early August as unemployment totals rise and the economy reels from the impact of Covid-19 and the 3 months of lockdown

Management plans to cut its 1,500 workforce were first floated back in December, with up to 200 job losses announced in March – but then held back because of the Covid pandemic – have been accelerated since the beginning of July.

In a complex rejigging of services, 194 NEL CSU staff are set to be displaced and at threat of redundancy, while 180 staff will have to compete for 106 posts, with management arguing that many of these might be considered for 240 new and vacant posts.

However the unions argue this is unlikely to work for many redundant staff, and are bracing for significant job losses.

Not agreed

The proposals have not been agreed by staff side unions, who are angry at finding out about the plans to proceed only by accident, and the management setting a pace which leaves insufficient time for the unions to consult their members.

With large numbers of staff having been redeployed to assist with coronavirus work, having had little contact with colleagues during that time, and CSU staff having worked long and hard in the effort to contain and combat the virus, there is anger at the efforts to speed through job losses at a time when jobs will be extremely hard to find.

Unions are also cheesed off that jobs are being axed by NEL CSU to save money while at the same time the organisation has been shelling out £2m a year to a company known as TET Limited for interim senior staff, including £242,000 a year for a director.

The unions, confronted with the need to resist an ideologically-driven proposal and the seemingly endless austerity regime in the NHS, are limited in campaigning options to defend staff with working in back-office services a low public profile.

They are pressing CSU bosses to offer a targeted voluntary redundancy scheme to minimise numbers of compulsory redundancies, and to engage with local trusts, the clearing house in London and other relevant organisations to seek out potential vacancies for at risk staff, the majority of whom are in roles such as procurement, finance, risk management and data analysis.

My fight to establish safeguards in private and NHS hospitals

Sarah Jane Downing is a writer, and a victim of Ian Paterson. She started a support group for those affected and is still campaigning on the issue.

THE STORY of Ian Paterson the rogue breast cancer surgeon who was allowed free reign to ruin thousands of lives over 17 years is now quite well known.

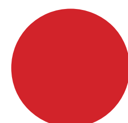
You can read the facts of what he did to us in the Bishop's Inquiry into Ian Paterson: but the actual horror of discovering that an operation that you only submitted to because Paterson told you it would save your life is something that does not come across with full impact no matter how many times it is told.

At the NHS Heart of England Trust Paterson operated on more than 1300 breast cancer patients, treating them – without their consent – to his own special Cleavage Sparing Mastectomy procedure, sadly as it had no grounding in medical science and defied the recommended mastectomy method of clearing all breast tissue in the affected area, it has to date caused the unnecessary death of 709 of the recipients.

Anomalies

I received a letter from Spire Healthcare out of the blue in July 2014 telling me that they had found 'grave anomalies' in my notes and I needed to discuss my treatment.

I was told that the operation Paterson had performed to remove the 'dangerous, rapidly growing' lump in my breast had been in fact entirely unnecessary and given a form to report the operation to the police as a criminal assault. There was no apology, no offer of a refund, and no support to deal with the horrific devastating news.



When things go wrong private healthcare patients are left completely without redress

Painfully aware that there must be others who had been treated with the same casual brutality, I put a call out in my local press to invite everyone in the same predicament to join me for a coffee party to raise funds for Macmillan Cancer Support.

That was the beginning of my support group for Paterson's patients, predominantly in the private healthcare sector, and the opening of a catalogue of disturbing discovery.

There is a general belief - largely fuelled by carefully curated advertising campaigns - that private healthcare is a safer, better option, unfortunately we have found the bitter truth to be entirely the opposite. When things go wrong private healthcare patients are left completely without redress.

There is an abject lack of accountability in the private healthcare sector which acts as a convenient

Spire's response to report of the Paterson Independent Inquiry

Justin Ash, Chief Executive of Spire Healthcare, said:

"Following the publication of today's report, we once again apologise for the significant distress suffered by patients who were treated by Ian Paterson in our hospitals. We accept that there were a number of missed opportunities to challenge Ian Paterson's criminal behaviour when these incidents happened prior to his suspension in 2011.

"We welcome the report and the voice it has given to patients.

"We fully support its recommendations and we will work with Government and the healthcare sector to ensure their implementation."

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'rogues charter' for surgeon's like Paterson and the healthcare companies who profit from all the unnecessary and wrongful surgeries they inflict upon their patients.

In fact contrary to the carefully cultivated claims about patient care, the private healthcare model in the UK actually allows that the contract is between surgeon and hospital, and patient outcome is consequently immaterial.

Where the NHS was forthcoming in acknowledging their part in enabling Paterson and relatively quick to compensate their patients, Spire Healthcare were determined to keep every penny that they and Paterson had extorted from us.

A solicitor from Spire's legal team even stated in a legal document that they were 'not obliged to supply competent surgeons', only surgeons, and therefore they were not accountable.

We have had to fight long and hard to get any compensation at all for our life altering injuries - even those who have been permanently disabled, those suffering secondary cancers, and the families of those who died unnecessary deaths - because the MDU withdrew Paterson's insurance due to his criminal activities.

Denial

Spire did eventually come up with a sum, but continue to deny any accountability for the surgeries performed by Paterson, at their hospitals, assisted by their staff, in accordance with contracts from which they profited.

We then had to fight for there to be a Government Inquiry into our case, and spent over two years working with the Inquiry team to define a set of Recommendations that we hope will be the first step in righting the issues that we have fallen victim to, and to developing suitably robust legislation that will bring accountability to the private healthcare sector.

Sadly the advent of the Pandemic has caused us to fear that our gains for patient safety will be undermined before the Recommendations are ever implemented.

With such additional stress on the NHS it is inevitable that the relationship with the private sector will become further entwined.

NHS patients treated within the private sector will have some protection afforded legally by 'Vicarious Liability' allowing them greater redress if their treatment goes wrong, but it is essential that patient safety concerns are at the heart of any and all possible future arrangements, so they are informed of the additional risks, and to offer protection to all before they accept treatment.

American investment

However, as soon as the closer arrangement between the NHS and the private healthcare sector was announced American investment corporation Invesco bought significant numbers of vote-carrying shares in Spire Healthcare.

Perhaps it is the fact that the company is so adept at making a vast profit in our private healthcare sector which is subject to fewer regulations than in the USA.

But more worryingly, as Invesco are closely linked with the Trump Administration, could it be the first move towards making sure access to the NHS remains firmly on the post-Brexit trade agreement negotiating table?

Coroner investigates deaths of Paterson's patients

Paul Evans

Inquests into the deaths of four women treated by rogue breast surgeon Ian Paterson have been opened.

Senior coroner for Birmingham and Solihull Louise Hunt launched an inquiry into the circumstances surrounding the deaths of Deborah Hynes, Marie Pinfield, Yvonne Cordon and Shionagh Gough, after a request from Birmingham police. Hunt told the BBC that it is likely that more Paterson related deaths will be examined, and the process will take many months.

It will mean further investigation into the role played by the private Spire Parkway Hospital the Heart of England NHS Foundation Trust where Paterson worked before being suspended in 2011 and jailed in 2017 for 17 counts of wounding with intent and three counts of unlawful wounding.

Inquiry

Both institutions were criticised in an independent inquiry chaired by The Right Reverend Graham James which delivered its report in February 2020, after taking evidence from 1100 patients over two years.

It took a "bewildering" 8 years to stop him working, after concerns were first raised in 2003. Over 1200 went under his knife for mastectomies, but 675 of them have now died. Women were subjected to ineffective and sometimes unnecessary procedures, often without their consent. leading to pain, premature death and mental torment and for many the consequences continue today.

Rev James said: "This report is not simply a story about a rogue surgeon. It would be tragic enough if that was the case, given the thousands of people whom Ian Paterson treated. But it is far worse. It is the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe"

Key questions on safety

The report's recommendations raise key questions of safety requiring urgent action from government, but have been overshadowed by events as the private sector has been a rushed back-up, supplying extra beds and staff during the Covid 19 response and have now been recruited in a multibillion deal to help the NHS bring down waiting lists

The government's response to the inquiry has been delayed by the crisis but they issued an official holding reply in April, "we remain committed to implementing considered and effective improvements in the areas set out in the Inquiry's recommendations."

FIve recommendations from Paterson inquiry:

- The NHS should stop sending patients for NHS-funded treatment at private hospitals until the for-profit sector implements the changes recommended by James.
- The NHS and private hospital groups set up a website where members of the public can see what types of procedures every surgeon in England is qualified to do, to help guide them where to be treated.
- Surgeons should have to write to patients outlining in plain English the procedure they are proposing.
- Patients should have time to think through whether to have surgery before undergoing it.
- Complaints made by people treated in private hospitals should be resolved by someone independent of the care provider.

Cumberlege inquiry: Patients still being harmed by system failures

Paul Evans

How is it that our system is still allowing repeated harm to be done to patients, by the clinicians, health providers and manufacturers, despite all the previous failures? The Cumberlege Inquiry suggests some answers.

"Tens of thousands" of patients, mostly women, have suffered avoidable harm, from three NHS interventions: surgical mesh implants, pregnancy tests and an anti-epileptic drug.

The independent review of the safety medical devices and medicines, chaired by Baroness Cumberledge, which interviewed over 700 people has now delivered a damning and insightful report about the impact.

The Inquiry heard how, over decades, patients had battled to be heard by the medical establishment, manufacturers and the NHS.

Rebuffed and discouraged by the authorities they were forced into long, hard-bitten campaigns just to receive basic acknowledgment and actions.

It is a story of outrageous failures; of many missed opportunities to stop using interventions that have proven harmful to some, before they went on to harm many more.

The Cumberlege report nails this systemic failure, but it's not the first time. Previous inquiries have also exposed the failure to act early, after the unnecessary deaths at Mid Staffs, and after the eleven infant deaths at Morecambe. It is true too of the response to the rogue breast surgeon Ian Paterson; who went on to wound and mistreat many more women, despite concerns having been raised with the NHS and private hospitals that he worked in.

The inquiry

The Cumberlege inquiry, ordered by Jeremy Hunt in 2018, set out to examine how the NHS in England responded to patient concerns about three interventions, but what they learned led them to conclude that similar problems could well affect other treatments too.

Echoing the popular view amongst patient groups that today's NHS lacks accountability, the Cumberlege report calls for a patient safety commissioner, a new voice, with statutory powers, to hold the system to account and who would themselves be accountable to Parliament.

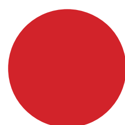
But why stop there?

In recent times big reorganisations of the NHS have created bodies that are corporate in structure with accountable public voices kept on the periphery of NHS planning, rather than at the heart of it.

And yet If you read them, you will find that the language of inclusivity and accountability spread liberally throughout NHS public documents.

The government trumpets its plan for new "publicly accountable integrated care", but it is evident from Cumberlege that this language is at best a rosy-glossing of the reality.

Cumberlege highlights a fragmented, under resourced system with conflicting financial interests, which puts up walls against patients' views and is therefore much more likely to fail to protect its patients from harm.



The Cumberlege report calls for a patient safety commiss-ioner, a new voice, with statutory powers, to hold the system to account

The report explicitly states that it believes that most NHS care is effective and acknowledges that innovations have saved many lives, however points to dangerous fissures in the system, such as the regulation of medical devices which, "without comprehensive pre-market testing and post-marketing surveillance and long-term monitoring of outcomes is, quite simply, dangerous"

Why didn't doctors listen?

Repeatedly, first-hand testimony to the inquiry suggested that patients were met with professional resistance and unwillingness to take their experiences seriously.

"almost universally women – spoke in disbelief, sadness and anger about the manner in which they were treated by the clinicians they had reached out to for help. The words 'defensive', 'dismissive' and 'arrogant', cropped up with alarming frequency."

Lack of knowledge was evident. Patients talked of having to "educate" their GPs to access the services they needed.

Conflicts of interests played a part too. In some cases, women were told they needed to go private in order to receive any treatment. Campaigners reported that clinicians have been paid or offered incentives by manufacturers, which they believe swayed their advice. The inquiry concluded that a public register of all financial interests should be kept, making these relationships transparent.

Why didn't manufacturers act?

Commercial interests and the need to rush to market to deliver returns to shareholders have prevented proper checks, according to evidence given to the inquiry.

The inquiry team also reported hearing much about research that "is funded by manufacturers that never sees the light of day because it is negative or inconclusive for the product in question, or is less than transparent in its declaration of conflicts of interest when positive findings are reported."

Currently, the regulatory body the Medicines and Healthcare products Regulatory Authority

The three interventions looked at by the Cumberlege Inquiry

Sodium valproate, an effective medication for epilepsy. But still today this medication causes harm to unborn children when their mother, unaware of the risks, takes it when she is pregnant.

Pelvic mesh, used to treat pelvic organ prolapse and urinary incontinence. Many women have suffered terrible complications following their mesh surgery.

Primodos, a hormone pregnancy test taken by women between the 1950s and the late 1970s, associated with damage to children, and those children now adults, are still needing care and support

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(MHRA), is not involved in the pre-market phase of the development of a medical device.

Generally, medical devices are not subject to the same level scrutiny as medicines and the inquiry is critical of the lack of regulation, but also of the way patient experiences are not being used.

By not talking to patients, the links with various adverse effects are harder to make, which helps to obscure the harm.

The inquiry pointed out that all too often the NHS does not compile treatment registers until after tragedy strikes - eg with PIP breast implants. This needs to change, by more often collecting data from patients directly, to help answer the question, is this medical device or treatment actually safe.

Some progress has already been made here as the government has introduced one of the new databases requested by the inquiry team.

Around the world though those suffering from the complications of having the polypropylene mesh inserted in them have faced resistance from the authorities and companies, and have often resorted to legal processes to seek redress, proving that governments need to step in.

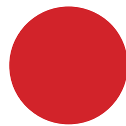
In the UK Valproate-affected families failed in their group litigation attempt, but in France the inquiry reported that a government-backed scheme will pay compensation to those who have suffered one or more complications.

Why weren't the complaints heard?

The inquiry concluded that there are many routes to complain, but most are limited in the scope of what they can do. Patients found it difficult to know where to start and to chart a course through these organisations, each time retelling upsetting details, only to be referred on to another service and the inquiry said some patients were "broken" by the process.

The report cites the General Medical Council as an example; it can only take complaints about a doctor's fitness to practise, but the fact that two thirds of the complaints they receive are about other matters, including non-clinical and parking disputes, shows the scale of the confusion.

There was widespread dissatisfaction with the way complaints were handled including by the GMC, Care Quality Commission and the various NHS trusts.



Generally, medical devices are not subject to the same level scrutiny as medicines and the inquiry is critical of the lack of regulation, but also of the way patient experiences are not being used.

The inquiry proposed that: "All organisations who take complaints from the public should designate a non-executive member of the board to oversee the complaint - handling processes and outcomes and ensure that appropriate action is taken. "

Where were the checks and balances?

Ultimately the inquiry believes there is a lack of accountability at the top and the public needs an influential figure to help "champion the value of listening to patients" and fight for the improvements in policy that are needed.

Patient groups point to murkier questions about the independence of the organisations tasked with regulation and advice, citing the MHRA whose funding comes from the pharmaceutical industry (for medicines) and 95% from the Department of health and social care (on devices).

Since the Mid-Staffs inquiry seven years ago, which reported comprehensively and made 290 recommendations, the NHS had made efforts to move away from a culture of blame, so that the system can openly learn from mistakes, but the Cumberlege inquiry reports that health professionals are resistant to speaking out.

Fear of litigation and blame are still strong barriers to making healthcare safer.

Subsequently legal duties around patient safety have also been introduced.

Since 2015 both NHS and private healthcare providers both have a legal duty of candour to inform patients about incidents of harm, provide support, information and an apology.

However, the inquiry reports that the system isn't being properly adhered to or regulated. No end of patients told the inquiry, "I was never told" about the dangers.

The inquiry concluded: "the healthcare system in its entirety does not work for some patients." and admitted that for hardworking NHS staff this will be hard to hear.

But responsibility for these failings must be shouldered by government, manufacturers, health bodies as well as the NHS. They must all be subject to change if the harm is to stop and lasting protection for patients found.

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Rescue Plan for post-Covid NHS

A great start for a Vision

RICHARD BOURNE comments on the Rescue Plan for the NHS published on July 5 by Health Campaigns Together and Keep Our NHS Public as a discussion draft on the way forward.

Campaigners are often accused of raising problems without ever suggesting answers. The excellent discussion paper produced by Health Campaign Together – 2020 vision for a port-Covid NHS shows the opposite.

The paper sets out the background, cites the evidence, identifies the key issues and has a set of sensible solutions. Surprisingly, it may well be that a broad consensus about the way forward is actually beginning to emerge.

Anyone interested in NHS policy and campaigning would be well advised to read the document and to contribute to the discussion it invites.

The background around the Covid disaster shows how slow the government was to act and how it failed to learn from its mistakes. It shows that years of inadequate funding and an ideology hostile to the public sector make things far worse than they could have been, and will make recovery harder.

The case for an inquiry is powerful; hopefully reporting before the next pandemic strikes. Years of a market approach and outsourcing have been exposed again as contracts were offered to unsuitable contractors without any proper oversight – instead of simply expanding the proven public sector provision – for example around testing.

Privatisation – and ministers' flawed belief in the superiority of everything private – may still be a small factor in terms of the total NHS, but the damage from this ideological stance goes far beyond that, and this is obvious to any impartial observer of the current crisis.

From the background and the evidence comes the challenge for this generation to find solutions on a scale reminiscent of the founding of the NHS.

Funding

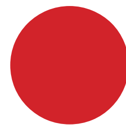
Much in the suggestions for the Rescue Plan is already established. Nobody doubts the need for greater funding for the NHS and a truly massive programme for investment to rebuild lost capacity and to get the NHS fit for the future.

The scale of funding required is way beyond what the government is offering and the investment just to tackle backlog maintenance and essential changes due cope post Covid dwarfs what has been on offer so far. A New Deal it is not.

After the money the staff: dealing with the enormous staff challenges could start by giving them better pay and conditions (as the French government has done) and doing what is needed to encourage better training, recruitment and retention is obvious.

But again there's no sign of the government and its People Plan getting the message. Rebuilding links to staff representatives after the idiocy of moves like the subcos might help.

Fragmentation due to Lansley's Act was as bad as the campaigners predicted. Issues like the role for public health and the management of the vast NHS estate were simply afterthoughts for the Act and it shows. Things are so bad that the NHS management (whoever they are) and even the Government were already ignoring the Act and during the pandemic this was obvious to all.



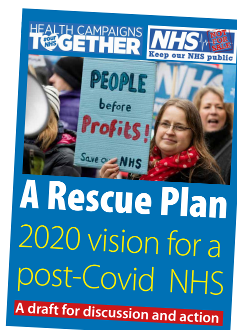
Years of inadequate funding and an ideology hostile to the public sector make things far worse than they could have been

Replacing Lansley's disastrous Health and Social care Act was already being discussed, with a possible Bill in the offing which went some way to addressing the concerns about marketisation.

To be fair the Plan is a bit vague on how the new non market structures it proposes for the NHS will work, and how the transition can be made without another massively expensive and disruptive redisorganisation – an opportunity for genuine discussion.

Democratic deficit

The Plan does however rightly point out the democratic deficit in the NHS, exemplified currently by the new non statutory and not representative Integrated Care Systems – stressing that the NHS will need greater local accountability.



Finally, despite being NHS focused the Plan rightly argues for reform of social care. A critic might argue that the Plan for the NHS is meaningless without a wider plan for wellbeing covering social care and other support services and benefits.

However, the need for radical reform making social care closer to an NHS style model of universal, comprehensive care, free at the point of need is welcome.

The emerging big discussion points are not so much about what is desirable, and more about how to get there from the current mess and a 20 year failure of policies to come up with a way forward.

We all know the social care system does not work for those who need care, those that deliver care and even those who try to profit from delivering care. Another area where contributions to the discussion would be welcomed.

At the heart of the social care debate is the whole question of the role for those who need care and support, a debate the NHS also needs to engage with – coproduction of health. Another huge area for debate which may also influence how the system is redesigned.

So a great start for a Vision – and lots still to discuss.

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