The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

Virgin Care given seat on ICS board

The concerns of campaigners that the proposals in the NHS White Paper to give statutory powers to "Integrated Care Systems" would lead to private companies sitting on ICS Boards have been proved justified..

Virgin Care's local managing director Julia Clarke is already listed as a member of the Partnership Board, the unitary Board which currently runs the ICS covering Bath and North East Somerset, Swindon and Wiltshire (BSW).

But a look at the Board Papers for a meeting on May 28 reveals that the Virgin boss is not only occupying a seat, but actively intervening to protect the company's interests. Minutes of the March meeting reported a discussion on the extent to which private sector "partners" would be required to be financially transparent towards the other providers within the ICS "for purposes of planning the independent/private sector's NHS related or NHS commissioned work." They noted Virgin's reluctance to share any information with the public:

"Virgin Care were prepared to consider greater transparency where the contract with BaNES and BSW was concerned, but had reservations about sharing information in public."

Not open at all

In response to this the NHS "partners" tamely rolled over, agreeing to action by Chief Financial Officers to "further discuss how the 'open book' approach could be applied to private / independent providers while protecting those providers' corporate and commercial interests" – in other words how to ensure 'open books' were not opened at all, and ICS contracts remain tightly guarded secrets withheld from the local public.

As this article was completed, the HSJ has revealed that BSW has been asking private providers to contribute £10,000 per year as a "voluntary" contribution towards the ICS running costs – a move questioned even by the private hospitals' body the Independent Healthcare Providers Network, whose CEO David Hare told the HSJ it was:

"Deeply problematic on so many levels. Just one – what happens in the event of a procurement and the winner has paid and a loser hasn't. Inducement? Reminder to me that lots more work is needed on ICS governance."

Nor is it reassuring to find that the Palliative and End of Life Oversight Group includes no less than TWO Virgin nominees, alongside two representatives of Medvivo, the private company supplying out of hours GP services and urgent care, which is also to be brought on to the ICS Partnership Board.

The ICS leaders' eagerness to embrace private providers

can also be seen on page 29 under Transformation Priorities for BSW, which includes "maximise use of independent sector, working in partnership to target capacity at longest waiters in system".

The White Paper leaves room for private companies to be incorporated into ICS Partnership Boards, but also into the main decision-making NHS Boards. Indeed the BSW

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Minutes from March enthusiastically noted that: "the lack of detail in the White Paper re governance arrangements at system and place levels indicated a level of freedom of design which should be exploited."

If the vague proposals wind up entrenching private companies on decision-making boards while excluding any representation for the public or NHS staff, it's clear that even meeting in public (as BSW does) would not ensure transparency or accountability.

* Meanwhile the National Union of Journalists at its online conference on May 21-22 has become the first TUC union to warn that ICSs represent a 'double threat to accountability' and call for any statutory ICS bodies to exclude private sector organisations and be compelled to meet in public and publish board papers. The NUJ motion also opposes plans to scrap long-standing powers of local government to block controversial changes and refer them to the Secretary of State and the Independent Reconfiguration Panel, and call for councils' scrutiny powers to be retained at the most local level.

John Lister

BMA votes 'no confidence' in NHS England over GP row

The GP committee of the BMA (GPC) has voted overwhelmingly to pause all meetings with NHS England until the situation with face-to-face appointments is resolved. The emergency motion said the GPC has 'no confidence' in NHS England's executive directors.

The vote at the committee's online meeting was triggered by a letter, sent by NHS England on 13 May, that told practices that they must provide face-to-face appointments for patients who request one, unless "there are good clinical reasons not to", and also to open their receptions to walk-ins within three days, with patients being triaged at reception.

The letter was incorporated almost completely into the Standard Operating Procedure on 20 May. NHS England claimed that the Royal College of GPs (RCGP) had backed its letter.

Now GPs are calling for the resignation of NHS England's medical director for Primary Care, Dr Nikki Kanani. A petition launched by grassroots organisation GP Survival – which represents 8,600 GP members in the UK calling for Dr Kanini to 'resign or be removed from her post' had gained over 1200 signatures by 20 May.

A clear wake-up call

In an open letter, GP Survival said its committee has 'no confidence' in Dr Kanani's leadership following the 'inflammatory and insulting' guidance sent to practices.

BMA GP Committee chair Dr Richard Vautrey said: 'For the representatives of England's GPs to pass a vote of no confidence in NHS England's senior leaders, is a clear wake-up call to NHS England and also for the Government."

He added that the letter was "woefully badly-judged" and "the final straw for many hard-working GPs who have gone above and beyond over the last year".

What is fueling GPs' anger is that they are open and they have been seeing patients face-to-face where appropriate throughout the pandemic and many surgeries have increased face-to-face appointments of their own accord at a pace that is sensible.

A survey by Pulse of more than 800 GPs conducted in the week before the letter found half were already doing home visits (54%) and non-urgent screenings (51%) as 'normal', with 35% saying the same for in-person enhanced services.

The NHS England letter came hot on the heels of a campaign by the Mail on Sundayclaiming that GP practices are closed and calling for them to be open again to patients. This has fueled considerable hostile coverage of GPs in certain sections of the media.

Sylvia Davidson

Greater Manchester hospital downgrade plans abandoned

The revelation by the Health Service Journal that the plan for reconfiguring hospital services in Greater Manchester has been "quietly dropped" – must raise questions over other plans across England that involve centralising services and downgrading hospitals.

The long-running, costly and controversial Healthier Together project was launched in 2014, seeking to centralise surgical specialties and emergency care on fewer sites while insisting that no hospitals would actually close.

The plan was to reduce the number of hospitals delivering high risk surgery from 10 to just four (Manchester Royal Infirmary, Salford, Stockport, and Oldham) with services downgraded at North Manchester, Wythenshawe, Tameside, Bolton, and Wigan – posing complex problems of access and the need for substantial expansion of beds and staff at the new specialist centres.

It was subject to a 15-week public consultation in 2015, and subsequently challenged in court by doctors at Wythenshawe Hospital angry at the loss of specialist activity who sought a judicial review – without success.

But the plan and the 2016 Sustainability and Transformation Plan were both effectively subsumed in the "Taking Charge" devolution process that allocated a combined budget £6 billion to cover health and social care in the whole of Greater Manchester from April 2016.

Now the Healthier Together website which displayed the initial consultation document and additional information appears to have been closed, and a search for 'Healthier Together' on the Greater Manchester Combined Authority website yields only links to Taking Charge.

Axe falls after millions spent

The decision to axe the Manchester plan after millions have been spent on consultancy and huge amounts of management time have been allocated to it echoes the top-level decision by NHS England to kill off the shambolic and costly Shaping a Healthier Future plan for North West London two years ago.

That plan, which threatened to axe acute services at Charing Cross and Ealing Hospitals, cost upwards of £72 million in consultancy fees – but never completed a business case, as its projected cost mushroomed above £1 billion.

Other areas still facing similarly ill-conceived schemes will be encouraged by this latest retreat to redouble the pressure on local MPs and councils to press for a full re-evaluation of the viability and affordability of the plans and their impact on local communities.

Inequality – from words to action?

Evidence that increasing social inequality in the past decade has resulted in growing inequalities in health keeps coming: but so far, despite warm words in local and national NHS plans and the Johnson government's hollow rhetoric on "levelling up" nothing significant has been done about it.

One problem is the complexity of the task of reducing social inequalities, as a new report, seeming to offer a fresh approach at least in the Midlands, points out.

But although the title might be off-putting, Socio-economic inequalities in access to planned hospital care: causes and consequences, researched by the Midlands and Lancashire Commissioning Support Unit (MLCSU), does as it promises.

It seeks explanations for the fact that richer people are more likely to access NHS elective care than poorer people, and estimates the impact of this on the NHS in the form of larger numbers of emergency admissions, and suggests actions to change the situation.

The report's readable Foreword, in stark contrast to the usual empty clichés from NHS England, is refreshingly blunt, and relentlessly focuses on the growing gap between rich and poor. It begins: "'Reducing health inequality' must be one of this country's most stable policy aims. With peaks and dips in emphasis, it has been featured consistently in policy statements since at least the late 1990s.

"Yet outcomes have got worse. Gaps between rich and poor have widened. Defying a trend that began in late Victorian times, gains in life expectancy have stalled for poorer groups – and have even fallen for women from the poorest backgrounds. Most recently, the pandemic has exposed the radically different experiences and outcomes of different ethnic groups in the UK."

Widening gap between richest and poorest

The report comes soon after the hard-hitting reviews by Professor Mike Marmot last year highlighting the worsening health consequences of the widening gap between the richest and poorest.

In February 2020 The Marmot Review 10 Years On, following on from the first landmark review Fair Society, Healthy Lives in 2010, warned: "The levels of social, environmental and economic inequality in society are damaging health and wellbeing."

"… For both men and women, the largest decreases in life expectancy were seen in the most deprived 10 percent of neighbourhoods in North East England and the largest increases in the least deprived 10 percent of neighbourhoods in London."

… "The gradient in healthy life expectancy is steeper than that

of life expectancy. It means that people in more deprived areas spend more of their shorter lives in ill health than those in less deprived areas."

Last December Build Back Fairer; the Covid 19 Marmot Review offered an even harder-hitting update on the evidence from the pandemic revealing that the inequalities impact most heavily on the BAME population:

"The links between ill health, including COVID-19, and deprivation are all too familiar. Less so have been the findings of shockingly high COVID-19 mortality rates among British people who self-identify as Black, Bangladeshi, Pakistani and Indian. Much, but not all, of this excess can be attributed to living in deprived areas, crowded housing and being more exposed to the virus at work and at home – these conditions are themselves the result of longstanding inequalities and structural racism."

An inverse law of healthcare provision

The new study, published in May by the Midlands NHS Decision Network focuses sharply on what can be done about it:

"This analysis has highlighted a problem that is directly within the NHS's ability to control. Many of the solutions, which will be the subject of a further project, will also therefore be within NHS control. So this report identifies a problem that local services can do something about."

The report notes previous research findings on inequalities of access to health care dating back to Julian Tudor Hart's famous 1971 Lancet article identifying the "inverse care law," stating that: "The availability of good medical care tends to vary inversely with the need for it in the population served."

In other words the greater the need (and generally the lower the income) the less health provision is locally available, while the wealthier areas with relatively lower health needs have generally much better access to high quality care. The new report does not quote Hart's further conclusion that:

"This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources."

The MLCSU report briefly refers to more recent studies that underline not only the greater access to health care of the least deprived groups, but also the negative impact of the 2012 Health and Social Care Act, which "prioritised the goal of efficiency at the expense of equity".

To redress the balance slightly it also cites March 2021 planning guidance from NHS England which does focus on reducing health inequalities, and requires local health systems to demonstrate how they are doing this in order to qualify for additional money from the Elective Recovery Fund.

The MLCSU research begins by highlighting the significant increases in elective treatment and outpatient attendances since 2005: elective admissions increased by 33% and outpatient appointments by 78% by 2018. Both rates of increase have been greater in the least deprived areas.

But while the improvements in waiting times between 2000 and 2014 were of more benefit to the least deprived areas, the report highlights four key factors in the more recent period of increased waiting times:

•Access to NHS-funded private sector treatment (following the development of Independent Sector Treatment Centres and the patient choice initiative in the mid 2000s) is substantially higher in the least deprived populations, and the gap is widening.

•Growth in rates of access to new imaging technologies tends to be slower in the most deprived areas.

•When the NHS seeks to limit access to certain forms of surgery (by restricting eligibility for "low value" procedures, lifestyle-based eligibility criteria and 'referral management'), rates tend to fall more rapidly in the most deprived areas.

•When the NHS introduces new screening programmes, interventions resulting from those programmes tend to increase more slowly in the most deprived areas.

Wider access could reduce A&E demand

The authors estimate an increase of 9.7% in elective admissions is needed to ensure the most deprived groups enjoy equal access with the least deprived in each STP area in the midlands. They argue this would cut emergency admissions by 1.3% per year:

"Our analysis represents compelling evidence to support the theory that increasing access to elective care for those in the most deprived areas would lead to reductions in demand for emergency care."

Most encouraging of all, the conclusions note that the report's findings require a critical look at the impact of some existing NHS policies:

"… this report is sufficient to support some immediate and targeted actions. The report suggests there may be value in reviewing the policies and procedures that seek to improve or control access to elective care and the process by which decisions about treatment are taken, ensuring these processes do not inadvertently disadvantage people living in the most deprived areas."

If it triggers even the beginnings of a serious review of some of the policies campaigners have warned about, it could be a significant step towards combatting inequalities – at least in the midlands region.

John Lister

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NHS funds siphoned off as beds stand empty

NHS waiting lists have soared to record levels, reaching almost 5 million, while waiting times also continue to increase, with over 436,000 patients waiting over a year for treatment in March, compared with 3,097 in March 2020, and up by 43% since January.

More than a third of patients are waiting longer than 18 weeks for treatment: the target for 92 per cent of patients to begin treatment with 18 weeks of referral from their GP has not been hit for five years.

So what is the cause, and what is the answer?

Although waiting times and the waiting list had been worsening prior to Covid, clearly the pandemic was the key factor in escalating the situation over the last year, forcing trusts to switch staff, resources and beds away from elective care, and forcing infection control measures that reduce capacity, including changes in wards to increase distance between beds.

NHS bed numbers plummeted by almost 10,000 in spring 2020, while numbers of beds occupied slumped by 35% – equivalent to almost 32,000 fewer beds in use.

While some of the closed beds have now reopened, the latest figures still show almost 6,000 fewer front line general and acute beds open in January-March this year compared with 2020, and over 10,000 fewer occupied.

In other words the NHS is still running at reduced capacity, just at the point it needs a major surge of activity to contain and begin to roll back the increased numbers waiting for treatment. But it also lacks the capital investment needed to reorganise the hospitals, and regain its lost capacity.

The answer from NHS England has been to throw money into contracts to block book private hospital beds, despite increasing evidence only a fraction of the booked bedswere used for NHS patients last year. Worse, the plan for the next 4 years is to divertup to £10 billion out of NHS budgets into paying up to 90 private clinics and hospitals to treat NHS patients.

This will leave NHS trusts with reduced budgets, complex staffing problems (with NHS doctors and nursing staff having to work away from NHS sites), and no cash to reopen their own closed and under-used beds.

It's also no answer: even if ALL of the 6,500 private beds which the NHS claimed to have block booked last year were opened up, this still falls well short of the 10,000 fewer NHS beds in use – and in four years the NHS will wind up weakened and chronically dependent upon private hospitals.

The policy is a boon for the private hospitals – but a body blow for the NHS hospitals that we all depend upon. Ministers and NHS England must be told to change course and invest in our NHS, not private hospitals.

Poor value from last year's block booking

Spending up to £2bn of NHS Covid funds on supposedly block booking private hospital beds in 2020 resulted in just 7 beds a day for Covid patients, according to research from the Centre for Health in the Public Interest (CHPI).

CHPI's Dr David McCoy told the Covid People's Inquiry that there were many days during the period when no private hospital beds at all were being used for Covid patients; on many more days just a single bed was used: indeed at no point during the year did private hospitals treat more than 67 Covid patients in a single day.

This contrasts with private sector claims to have treated 3 million NHS patients under the contract with NHS England in the 12 months to March 2021 – claims which confusingly lump together numerous activities, most of which do not require beds.

The Independent Healthcare Providers Network (IHPN) boasts of "providingoperations, chemotherapy sessions, diagnostic tests and consultations" to NHS patients, including 160,000 NHS "cancer and cardiology treatments." At the same time private hospitals, financially rescued by the NHS block booking, increasingly reverted to treating large numbers of privately-funded patients.

The small number of Covid patients treated by the private hospitals is not a great surprise, since they were always ill-equipped to do so. They are mostly small (212 hospitals with 8983 beds, averaging just 42 beds per hospital) and most are geared exclusively to dealing with uncomplicated elective surgery for insured people of working age or older people wealthy enough to pay out of pocket.

Few of them therefore have an Intensive Care Unit: most rely on NHS resources when things go wrong as well as using NHS specialist staff working on a part-time, sessional basis.

Right-wing call for 'Marshall Plan'

Amid widespread concern at the expanding role of US health insurer Centene in the NHS – buying up profitable GP practices and seeking contracts from the Health Systems Support Framework to support "back office" functions in Integrated Care Systems – the Daily Telegraph has plugged a call from Andrew Haldenby (co-founder of a right wing "research body") for an equivalent of the Marshall Plan to rescue the NHS.

For those unfamiliar with the Marshall Plan (which is a recurrent stock analogy in the Telegraph, whose readership's ideas seem locked in World War 2 and its aftermath) it was a postwar programme of American financial aid to reconstruct the ravaged economies of western Europe and thus limit the influence of Stalin and Communism.

Haldenby's "Marshall Plan" involves the use of American (and Indian) investment to help bring down the large and growing NHS waiting list – and appears to rejects any increased spending by the British government, arguing: "Such a plan need not be based on the extreme spending and tax increases some are arguing for."

This kind of statement is both a clear embrace of private sector solutions in preference to expanding the NHS, but also reflects a persistent delusion of the neoliberal right wing that private cash can be used to treat NHS patients without any cost.

Precisely the same delusion led Tony Blair's government to sign contracts for over 100 hospitals to be built with the disastrously expensive Private Finance Initiative, saddling the NHS with debts reaching into the 2040s – debts which have to be serviced from NHS revenue budgets … and of course ultimately the taxpayer.

In an earlier version of the same article for the Conservative Home website, Haldenby insisted "The solution does not lie in a "bigger" NHS," before going on to propose building at least 42 new units: "high-volume centres on the model of the South West London Elective Orthopaedic Centre … the largest hip and knee replacement centre in the UK and one of the largest in Europe."

The wheeze is that rather than funding these with public money, "the NHS should call on all national and global resources. Some of the centres could be joint ventures with experienced providers such as the Cleveland Clinic and Apollo Healthcare in India."

To limit NHS spending, Haldenby rattles out a whole catalogue of old, discredited ideas about diverting patients from hospital outpatients, reducing demand for A&E and expanding community services. He asserts without evidence that "Community services will provide much faster diagnostic scans, often working in partnership with private firms."

Nowhere does Haldenby address the cost of his proposals, or restoring the reduced capacity of the post-Covid NHS, the huge backlog bill for maintenance that has resulted in NHS hospitals virtually falling down, or how to fill the 100,000-plus NHS vacancies.

But of course his chosen audience or ageing Brexiteer Tories will not bother him with any awkward questions on such issues – as long as he talks about the war.

John Lister

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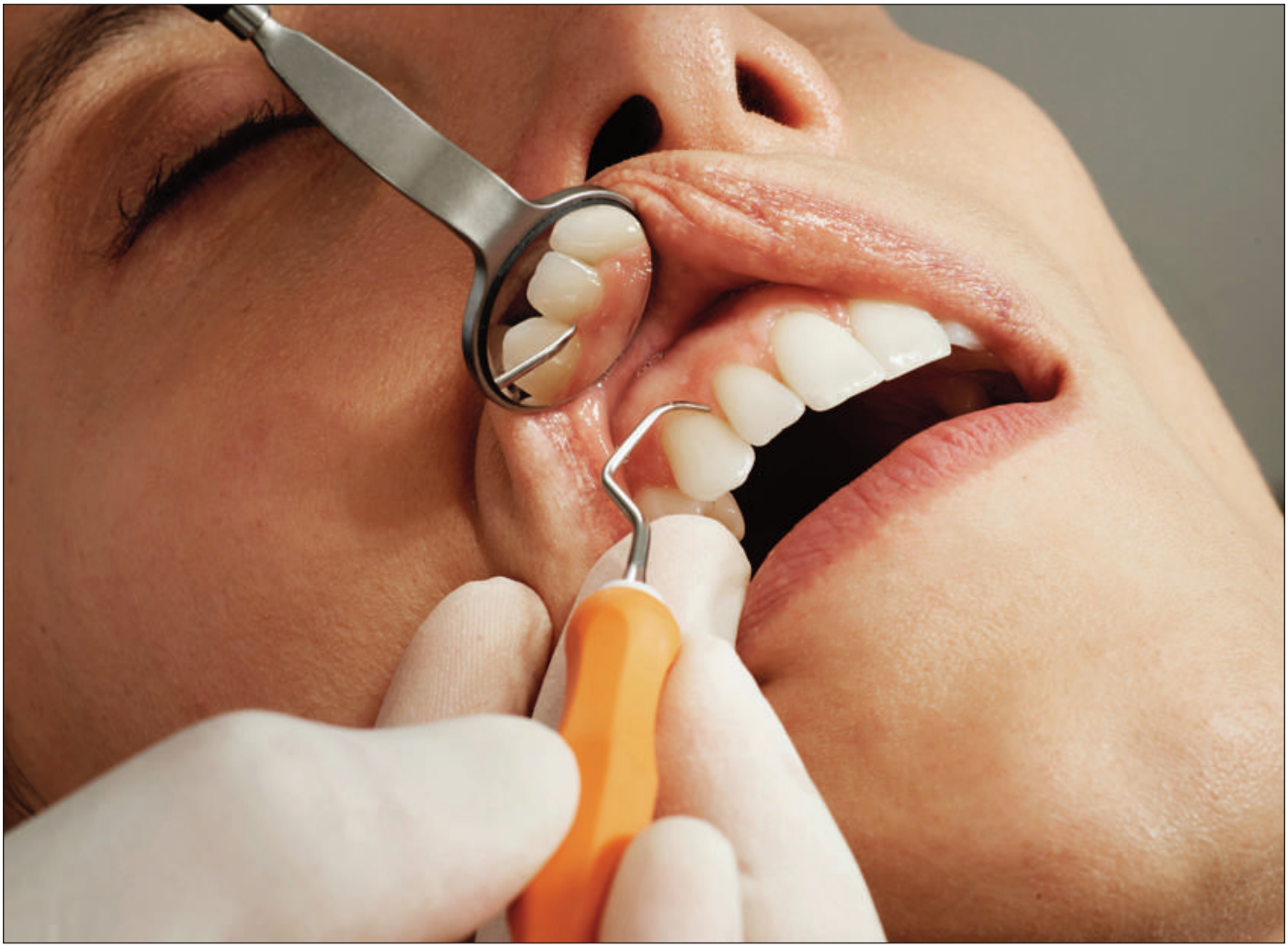

NHS dentistry struggling to survive

NHS dentistry is facing a "twin crisis of access and affordability", according to the watchdog Healthwatch England, which means in reality for many people NHS dentistry no longer exists.

The latest data from Healthwatch has found some patients being told they have to wait up to three years for appointments, although if they go private they can be seen within a week, with other patients unable to find a dentist that will do NHS work.

Healthwatch England has been monitoring how dentistry has fared during the Covid-19 pandemic. Over many months the organisation has documented a catalogue of problems with accessibility and affordability with the two groups suffering the most – those on low incomes and ethnic minorities.

This latest report collates the experiences of 1,375 people from January to March 2021, plus a Healthwatch commissioned poll of 2,019 adults that looked at people's experiences of NHS dentistry during the pandemic. The report also pulls in data and people's experiences from earlier in 2021 and in 2020.

"One patient ended up in hospital for three days, after taking too many painkillers to relieve severe tooth pain when no emergency dentist could be found"

Of the 1,375 reports from local teams, it was found that 80% of people found it difficult to access timely care and 59% reported a negative experience of care, with just 3% of people telling them about a positive experience.

The problem of access includes difficulties in finding an NHS dentist to register with and then long waiting times. Being unable to access care or having it delayed has left people with pain, swellings, and broken teeth, fillings and dentures. Other patients have had appointments cancelled in the middle of a course of treatment, such as root canal surgery. Oth-

ers have found that when they have tried to book a dentist appointment, they have been removed from their practice list.

The Healthwatch poll on the public's attitude to access and affordability of dentistry found that most people (61%) feel that NHS dental treatment charges are expensive, with over a quarter (27%) of respondents saying they either struggled to pay or avoid dental treatments altogether because they cannot afford the costs.

The poll also backed up the reports that Healthwatch has received from its local teams – many people feel pressured into paying private fees to get all the dental treatment they need, difficulties booking an appointment, and in finding information on treatment fees.

For those requiring emergency dental treatment there are some truly shocking reports, with many people being told to self-medicate whilst they wait for an appointment or try to register with a dentist. Being left in pain and told to self-medicate can have serious consequences – Suffolk Healthwatch reported that after unsuccessfully trying to find a dentist for three years, one patient ended up in hospital for three days after taking too many painkillers to relieve severe tooth pain when their condition worsened and no emergency dentist could be found. The patient still does not have a dentist and is still in pain.

Patients even advised to try DIY

Healthwatch has been told that when rung by people with a dental emergency NHS 111 has advised people to gargle with salt-water and just to continue trying to get an appointment.

Experiences reported by Healthwatch teams in late 2020 include some people calling over 40 practices to find an NHS dentist, and pulling their own teeth out when they couldn't bear the pain.

Patients have been told by practices to use DIY filling kits while they wait for an appointment and there has been an increase in reports of being repeatedly prescribed antibiotics to deal with the pain, but with no prospect of an appointment to actually fix the problem.

Healthwatch England has called for major changes to NHS dentistry, including a radical reform of the way NHS dentistry is commissioned and provided.

"Over many months Healthwatch England has documented a catalogue of problems with accessibility and affordability, with the two groups suffering the most – those on low incomes and ethnic minorities"

Imelda Redmond, national director of Healthwatch England, told PA: "The twin crisis of access and affordability hitting NHS dentistry means many people are not able to access timely care – and the poorest are hardest hit….Reform of dental contracts needs to be a matter of urgency for this government. New arrangements should include making access to NHS dental services equal and affordable for everyone, regardless of where people live, their income and ethnicity."

The failure of dentistry now will lead to long-term harm to thousands of people – the result will be further pressure on the NHS in the future.

New guidance impacted on urgent care

The government's new guidance introduced in January 2021 and revised 1 April 2021 on how dentists will be paid and what targets they have to reach has led to dentists choosing to do straightforward work, such as check-ups, rather than difficult time-consuming urgent work.

This came to light as soon as the targets were announced in January 2021, via a leaked email from a leading UK dental chain, in which its dentists were instructed to limit urgent care in order to meet the targets. The system means it is easier to achieve the targets and escape financial penalties via simple routine check-ups rather than time-consuming urgent care.

Practices that don't meet the targets have to return two thirds or more of their NHS funding for that quarter, leaving practices under severe financial pressure, which in turn threatens patient access. In order to meet the targets, dentists would have to increase visits to the surgery and this in turn will make effective social distancing very difficult to achieve and at odds with clinical guidance.

NHS dentistry is struggling to survive – with a combination of the government targets that have to be met, whilst working with the Covid restrictions potentially leading to an exodus of dentists from the NHS service, according to the BDA. A survey conducted by the BDA shows that nearly half (47%) of dentists indicate they are now likely to change career or seek early retirement in the next 12 months should current COVID restrictions remain in place with the same proportion saying they are likely to reduce their NHS commitment.

Sylvia Davidson

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Cummings' care homes claim hits home

The most damning element of Dominic Cummings' mesmerising seven-hour testimony before a parliamentary select committee this week – and probably the one most likely to dent the reputation (and possibly the careers) of both the health secretary and the prime minister – was his demolition of the government's record on protecting care home residents over the past year.

In his testimony Cummings claimed that health secretary Matt Hancock had assured him at the start of the pandemic, in March last year, that elderly hospital patients would be tested before being discharged back to care homes, as part of a national drive to 'put a shield' around the sector while freeing up beds ahead of an expected surge in covid cases.

NHS guidance issued on 19 March did, indeed, suggest that care home residents should "not remain in an NHS bed" unless seriously ill, but two weeks later further guidance emerged advising that care home residents didn't need a negative covid test before being discharged – and that even if elderly patients tested positive they could still be admitted back to their care homes if PPE-based practices were in place.

It would be another two weeks, in mid-April, before the government publicly claimed that all patients would be tested before being discharged. But by this stage around 25,000 elderly patients, many of them untested, had already been transferred out of hospital, leading the National Care Association chair Nadra Ahmed to tell the BBC that the government had "completely abandoned" the sector.

Statistics released just two weeks ago by the ONS suggest there were 11,706 covid-related deaths in care homes during the crucial months of March and April last year, contributing to a total of 40,000 such deaths that have occurred during the 12 months leading up to April this year.

"Hancock argued that the testing capacity simply wasn't in place when the patient discharges began, but offered no explanation why the discharge policy wasn't then delayed"

It's no surprise therefore that Hancock has now twice refused to directly address Cummings' 'shield' claim: when answering an 'urgent question' on the matter in the Commons the next day, and then again a few hours later when presenting that day's Downing Street covid briefing.

On the first occasion, addressing his fellow MPs in parliament, Hancock dodged the question, instead drawing a parallel with the situation elsewhere in the UK. "The Scottish government, with its responsibilities for social care, also had to respond to the same challenges and dilemmas that we did," he asserted. "It was the same challenge for the administration in Edinburgh as it was here in Westminster."

But Hancock may have simply been aware of revelations in the Scottish media a day earlier relating to covid-related death rates north of the border. New figures from the Care Inspectorate and National Records of Scotland – released only after an FoI transparency battle with The Scotsman, The Herald, DC Thomson and STV – show the rates were more than six times higher in larger facilities across Scotland.

At the Downing Street briefing, Hancock appeared to fall back on the argument that the testing capacity simply wasn't in place when the patient discharges began, but offered no explanation as to why the discharge policy wasn't then delayed.

So Cummings' claim regarding Hancock's failures still looks robust – fact checks by various news outlets certainly back it up – and renders prime minister Boris Johnson's lazy follow-up response (simply: "No, I don't think so"), when his former spad linked those failures to thousands of unnecessary deaths, as chillingly hollow..

Martin Shelley

Free prescriptions save money

New research from Canada has confirmed the point campaigners have been making for decades: that prescription charges deter or prevent poorer patients from complying with the treatment they need – and offer only an illusion of financial savings.

A two-year study involving almost 800 patients in various parts of Ontario showed that regular use of prescribed medicines was 35% higher amongst those receiving free prescription drugs than those left to fend for themselves, while free distribution of medication also reduced healthcare costs, including hospitalization, by an average of $1,222 per patient per year.

Canada is the only country with universal healthcare that does not have a universal pharmacare program to subsidise or exempt vulnerable and low income patients from the full cost of prescription drugs.

But the findings also underline the value of scrapping charges on prescriptions in the NHS, currently standing at £9.35 per item, and posing barriers to care for many on low pay that just exceeds the upper limit for exemption.

The only reason there has not been wider campaigning on this has been the very high level of exemptions covering 40% of the population, meaning that around 90% of prescriptions in England are dispensed free of charge, while the NHS in Wales, Scotland and Northern Ireland abolished all prescription charges years ago.

The Department of Health and Social Care collected a total of just £614m in prescription charges in 2019/20, towards total expenditure of £137 billion – less than half of one percent.

The potential savings that could be achieved by ensuring all those on low incomes can access all the drugs they need have not been estimated: but the Canadian research suggests that scrapping the charges could easily pay for itself – and end the misery for large numbers of patients.

John Lister

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To help secure the future of our NHS through campaigning journalism, please support us

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 – we track contracts and collect evidence about failures of private companies running NHS services

First we must escape the covid-19 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 to account 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 virus, we are now asking those who can to give as much as you can afford.

We suggest £5 per month or £50 per year for individuals, and hopefully at least £20 per month or £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 posted 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, please email us at contactus@lowdownnhs.info