THE lowdown

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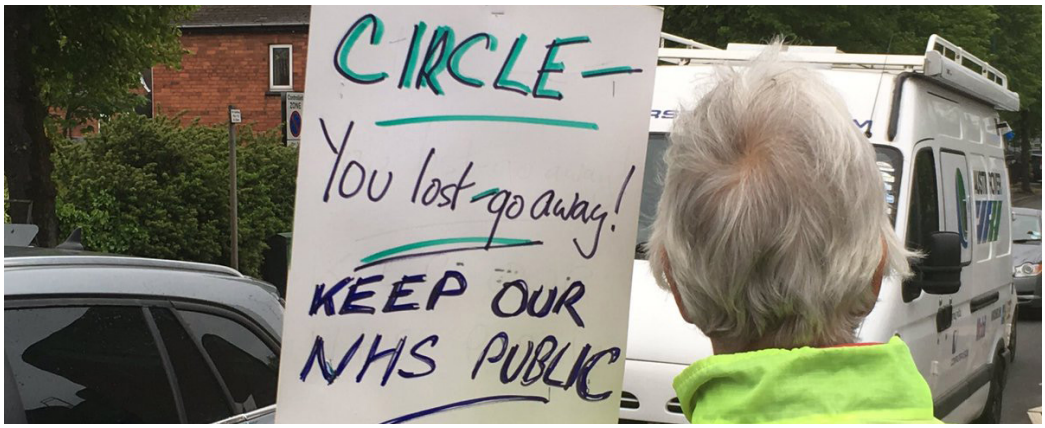
Informing, alerting and empowering NHS staff and campaigners



Circle launches fresh court challenge over lost contract

Circle Healthcare, the private company currently running the Treatment Centre on Nottingham University Hospitals Trust's Queens Medical Centre campus will go to court on May 15 to protect its profits. It has launched a legal challenge to the Rushcliffe Clinical Commissioning Group (CCG) decision to award the £320m contract to the Nottingham University Hospitals trust.

Having lost out twice to the NUH Trust in the new contract to run Treatment Centre services, Circle is now going to court for a second time, claiming the Trust can't possibly treat NHS patients for less money, and that bringing the contract back in-house would be "unrealistic" and "not in patients' interests".

One especially bizarre claim by Circle, a company owned by hedge funds that has yet to deliver a profit, and whose private hospitals depend upon NHS-funded patients was that NUH could not be seen as reliable because it was running a deficit.

The controversial company has had a number of major failures in the past, not least the collapse of acute dermatology services in Nottingham after they took over that contract.

Circle's action is due to be heard on Wed 15th May in the High Court's Rolls Building in London's Fetter Lane.

Circle now allege that the cost of in-house services would be higher, due to staff benefiting from "improved NHS terms" – an admission that they have been underpaying staff up to now.

The in-house bid has been approved both by the CCG and NHS Improvement's Regional Director of Finance.

Campaigners are stepping up the pressure to ensure Circle don't get another chance.

Hundreds of leaflets were handed out on May 9 in an early morning lobby outside the QMC by 20-30 campaigners including Keep Our NHS Public, UNISON Health NUH branch and officials, Nottingham Unite Health, Unite Community and a newly elected local councillor.

UNISON are starting a campaign to persuade Circle they will be better off in-house (frontline staff wages are better for starters!). UNISON are also initiating an on-line petition

More surprising support came at a meeting of the Integrated Care System Board that day, where the Chair agreed to circulate a campaign leaflet prior to a discussion on Best Value, and KONP have now been invited to a separate meeting with Board members.

Sodexo workers win pay deal after 2-day strike action

Following two days of strike action at the beginning of May, catering staff employed by contractors Sodexo at Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust have been offered a pay deal matching the increases for NHS staff agreed to in 2018. The action was jointly coordinated by UNISON and the GMB.

70 NHS catering staff members were had been transferred to Sodexo when the trust privatised the service in January 2017. UNISON now argues that this has cost each individual around £1,000 per year, because their pay did not automatically follow national NHS pay scales.

The strike action at Doncaster Royal Infirmary and Bassetlaw Hospital has been part of a series of similar recent actions taken by trade unions against a variety of private contractors that have refused to keep staff on equivalent pay to NHS national rates.

Last month support staff at Liverpool Women's Hospital also won an agreement from contractors OCS to increase pay to NHS levels, in a settlement worth as much as £2,000 to some staff.

IN THIS ISSUE

Public mood hardens against private firms running the NHS

Paul Evans

160,000 people have called on the government to end the market driven NHS, but firms dispute that this shows that the public are rejecting private sector involvement.

A consultation set up by NHS England to invite views about plans to re-shape the NHS has received their biggest ever response from the public. A key part of the listening exercise surrounded plans to remove the rules that currently force the NHS to compete with the private sector and charities for contracts.

Testing the popularity of outsourcing the campaign group 38 degrees asked 170,000 of their members whether "local health services should typically be run by the NHS, not private companies", an overwhelming 97 per cent agreed or strongly agreed in an online survey.

The group have published their survey ahead of the official consultation response from NHS England.

Countering the survey findings, David Hare, the CEO of the Independent Healthcare Providers Network said in comments to the HSJ, that they were out of step with other polling "credible research organisations such as ComRes and Ipsos MORI has shown time and time again that a representative sample of the public are entirely comfortable with independent organisations delivering NHS care".

Newest evidence

However, an analysis of the most recent polls reveals that the public are becoming far cooler about the idea of firms delivering NHS care. Ipsos Mori found in their 2017 public poll that there has been an increase in the number of people who prefer to use NHS services – 55%, up from 39% in the 2014 British social attitudes survey.

Opting for the NHS over private providers is an even more telling choice by the public given the pressures on NHS. For the first-time satisfaction rates are falling, but the public's belief in the core principles of the NHS is holding fast.

Nine out of ten still back an NHS that is free at the point of access and provides a comprehensive service to everyone.

There are also signs that voters are more likely to back nationalization policies over those that give the private sector more control. YouGov poll found that only 10% of the public believe the NHS should be privatized and run by private companies, with 83% saying it should be nationalized and "run in the public sector"

It is true that, at one stage polls seemed to show a small majority of the public to be indifferent about how NHS care was delivered - as long as it was free at the point of use.

A YouGov poll found only 10% of the public believe the NHS should be privatized, with 83% saying it should be nationalized and "run in the public sector"

However, a succession of spectacular outsourcing failures has crumpled public confidence. Firms that haven't made profits have frequently dropped contracts, leaving the NHS to resurrect service provision. Recently Virgin announced it is to walk away early from its £270m contract to provide services to frail older people in Staffordshire.

Back in 2014 Serco abandoned all its NHS work after profit margins were squeezed and accusations that it fiddled performance figures and left GP services in Cornwall dangerously understaffed.

A year later Circle gave up running an entire NHS hospital in Cambridgeshire after the health watchdog produced a damning report on its failings *(see page 5).

More recently the collapse of Carillion and the repeated problems with Capita and G4S contracts have made them household names and piled reputational damage on to the outsourcing project.

The public view of private companies is becoming more nuanced. The Panama Papers and other tax scandals explain why nine out of ten people believe tax avoidance by large companies is morally wrong.

However, extensive cuts and restricted spending on public services have pushed more commissioners towards the private sector, but the shock of this long period of austerity has also now shifted opinions on these key national policies.

Only one-fifth now think that there is a real need to cut spending on public services to pay off the national debt and most people would pay extra tax to see spending on the NHS rise.

Campaigns move governments

In the months after the Health and Social Care Act 2012 was passed the government confidently launched successive new ways to involve private firms, but now, seven years on it seems that most privatisation projects in the NHS are toxic to the public.

In the past few months a plan to privatise PET scanning in Oxford has resulted in a vigorous local campaign, pulling in MPs and councillors to back the opposition. NHS England has already attempted one climb down, but the local objectors are yet to be convinced. In fact, after announcing that it is trying to persuade the government to scrap the section 75 rules that enforce competition, it is the credibility of NHS England that is on the line.

They must convince a battle hardened constituency of NHS campaigners that they are genuinely steering the NHS away from markets and the privateers. However, the emergence of new privatisation projects, like that in Oxford are raising real doubts.

We Own it and Keep Our NHS Public have worked together to encourage the public to answer NHS England's consultation. They encouraged supporters to send NHS leaders a letter that reads

"I'm really pleased that you're calling on the government to abolish section 75 of the NHS Act….But I want you to go further. I want an NHS which is publicly provided, publicly funded, and publicly accountable."

Campaign groups suspect that the NHS integration project will still provide opportunities for private companies to expand their control.

They cite the NHS contract for Integrated Care Providers as evidence, as it gives private companies the chance to take on the lead budget holding role. Even if this is unlikely, say campaigners the new local partnerships of providers also lack accountability and proper governance.

In the last two years petitions against privatisation have collected millions of signatures and provoked a handful of judicial reviews.

The public have become steely and active in their opposition. After being taken to the high court there is no doubt that NHS leaders are more realistic about the public mood.

NHS England are also clear in their view that competition and market rules are dysfunctional, working against their new integration plan for the NHS. The public want them to go further, to banish an era of private sector incursions and you can bet that campaigning won't stop until they do.

Pensioners challenge Staffs cull of community beds

The campaign to halt plans to axe half of the community hospital beds in north Staffordshire and Stoke on Trent, with the total closure of beds in four of the five hospitals, which we reported in the first pilot issue of ***The Lowdown***, is continuing, and now the North Staffs Pensioners Convention (NSPC) has published a detailed response.

The two clinical commissioning groups published slightly revised plans last December, which would result in some hospital sites being sold off and all the beds at Leek, Longton, Cheadle and Bradwell hospitals set to close for good

These were the latest retread of the unpopular **'My Care My Way - Home First'** proposals which were challenged by Stoke on Trent city council and subsequently heavily criticised in December 2017 by the Independent Reconfiguration Panel, which noted that:

> "Nearly three years after proposing the new model, the NHS has not yet demonstrated the case for change.
>
> "The NHS has failed so far to show the capabilities required properly to implement My Care My Way - Home First […]
>
> "Although there has been extra investment in out-of-hospital services, the closure of community beds to date is associated with cost cutting rather than the implementation of better services with improved outcomes for patients."

The IRP also commented that "Without a solid case for change, the NHS has not established a robust programme for change and experienced a number of false starts. The bed modelling presented to the Committee in September 2015, has proved entirely incorrect and misleading."

And it agreed with the council and campaigners in dismissing the specious claims by the CCGs that the closures they had implemented were only "temporary":

"The myth of temporary closures is reinforced by the NHS confirming that they have no plans to reopen the beds and that their financial plans for the last two years rely on almost £10m of savings from the closures."

However the Panel decided not to carry out a full review or call for the CCGs' plans to be dropped, despite renewed local calls for the beds to be reopened.

The NSPC response, published in their May bulletin, underlines the consequences of the CCGs' irresponsible attempts to make cuts by closing 187 beds, and commissioning 55 places in privately run care homes:

"The impact of your reckless closure of Community Hospital beds has already been felt across the local Health system – particularly on the Royal Stoke Hospital and waiting times at the Accident and Emergency department."

They go on to show the problem of relying on poor quality care homes

"in practice, you have commissioned beds in Brighton House – that found Legionella in the water pipes, and Stadium Court that was deemed inadequate by the CQC and closed to new entrants. […] Of 86 beds that you commission from the independent care home sector, 51 are in homes that require improvement. This is a complete failure to safeguard the people in your care."

So far there is little sign of any change of direction by the CCGs, who seem determined to add further proof for campaigners who argue that NHS rhetoric about "integration" and new services is simply a smokescreen for greater dependence on profit-seeking care homes and short-sighted cutbacks.

Virgin gives up on underfunded Staffs contract

Virgin Care is set to abandon its community care contract in East Staffordshire by 2020 after failing to reach a funding agreement with the CCG.

The seven-year fixed price contract is worth £270m and covers care for patients with long-term health conditions and frail, older people.

East Staffordshire CCG signed the deal - which began in May 2016, arguing it could not shoulder the cost of integrating the service. Virgin Care took on the role of prime provider, which meant that it both commissioned and provided services.

However, in October 2018, following an 18 month dispute over funding, Virgin Care terminated all the commissioning elements, although it continued to provide community nursing, specialist nursing and care coordination.

The CCG had to take over direct control of the sub-contracts that Virgin had put in place, whilst negotiations took place, but agreement could not be reached.

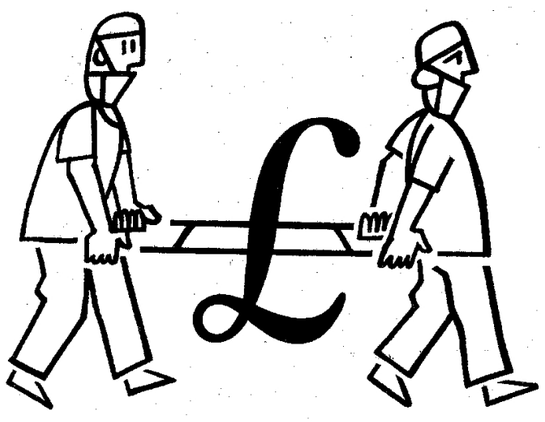
The private provider was reported by the HSJ to be demanding an extra £5m. Finally Virgin Care sent a 12 month termination notice to the CCG.

Nearby Burton Hospitals Foundation Trust was affected by the dispute as Virgin subcontracts services from the trust and its finances were put in jeopardy because contracts were stalled.

Under NHS contracts, private companies can abandon contracts with no penalties. Virgin Care is just the most recent company to have done so for financial reasons. Other terminated contracts include those in GP services, out-of-hours services and hospital services (see facing page for more examples).

The Staffordshire Improving Lives programme was claimed to give patients more control of their own care,

Under NHS contracts, private companies can abandon contracts with no penalties. Virgin Care is just the most recent company to have done so



including support using telecare and remote monitoring technologies.

The contract was expected to cover 38,000 people with long term conditions, as well as an estimated 6,000 elderly people. It included a measurement of performance against patient outcomes such as rate of falls, admissions into hospital, diabetes blood test management and patient mortality.

But since there is not enough money in the pot for either the CCG or Virgin to deliver the contract, the future of these services must be in doubt.

Plan for public-private mental health link-up is finally scrapped

A long-delayed innovative collaboration between public and private providers for child and adolescent mental health services (CAMHS) in Kent, Surrey and Sussex has been abandoned, according to the HSJ.

The pilot, part of NHS England's Mental Health Forward View, was meant to go live in October 2017 with Surrey and Borders Partnership Foundation Trust as its lead provider, taking control of the budget responsibility for decision making for tertiary mental health care, including adult secure care and tier four CAMHS.

Under the scheme the lead provider then partners with other organisations and would have included the largest number of private providers in the country including; Elysium Healthcare, Huntercombe Group, Priory Healthcare and Cygnet Healthcare.

With the exception of Elysium Healthcare, all these organisations have received highly critical reports from the Care Quality Commission (CQC) in recent years.

An initial delay put the start date back to October 2018. According to HSJ, the staff were told at Christmas of the scrapping of the pilot, but no public announcement has been made. The pilot is not listed on the NHS England's website.

The reason for the pilot being dropped are numerous, according to the trust. The structure, with a lead provider, is still very much way that mental health care is set to develop. (see following story)

Problems with private providers

The Priory Group has been sanctioned in recent times for the deaths of three adolescents - Amy El-Keira at Ticehurst, Sara Green in Priory Royal, Cheadle, and George Werb in the company's hospital in Southampton.

More recently in February 2019, the Priory's hospital for children with learning disabilities in High Wycombe was closed, following a CQC report that gave the unit an overall rating of 'inadequate'.

The hospital had only opened in April 2018 and catered for children aged 13 to 17 with learning disabilities and/or autism.

In 2018, two of the company's hospitals, its Roehampton hospital in Wandsworth and its hospital in Southgate, North London, received very critical CQC reports. Both were rated "requires improvement" overall by the CQC, following unannounced inspections.

The CQC rated the Southgate hospital as "inadequate" for safety and noted several concerns across its child and adolescent mental health services, acute adult wards and substance misuse services.

In December 2018, an inspection by the CQC of Huntercombe's hospital in Norwich found serious concerns. The CQC took immediate action to protect those using the service, including enforcement action to remove the registration for the hospital.

The Huntercombe Group then closed the service and the children and adolescents had to be found places elsewhere.

The CQC issued a highly critical report in early 2019 on Cygnet Healthcare's CAMHS' unit at its hospital at Godden Green, in Kent, and Cygnet closed its CAMHS unit in Woking in late 2017 following a CQC inspection.

The terminators: seven companies that walked away from NHS contracts

In 2012 **Circle** won a ten-year contract to run the NHS Hinchingbrooke hospital, but pulled out after only two years following a lack of financial success and damning reports from Care Quality Commission (CQC).

The CQC raised serious concerns about care quality, management and the culture at the hospital. It found a catalogue of serious failings that put patients in danger and delayed pain relief. The hospital was put in to special measures; the first time the CQC had taken this step.

In December 2013 **Serco** announced that it would be pulling out of its contract to run Braintree hospital: the contract was handed back to Mid Essex Hospital Trust, nearly a year early.

Also in December 2013 **Serco** announced that its contract to provide out-of-hours care in Cornwall for Kernow CCG would end 18 months early. The contract had been dogged with controversy; Serco had to admit that some of its staff had falsified data to make the company's performance appear better than it was and whistleblowers had raised concerns about poor staffing levels.

Image: The Poke

The Public Accounts Committee reported the service to be falling "unacceptably short" of essential standards of quality and safety. In 2013 Serco unsuccessfully tried to sub-contract the work to Devon Doctors, the GP consortium that had failed to win the original bid; Serco had won the bid as it was cheaper.

The company's other major contract with the NHS for community care in Suffolk, did not produce the profits the company was hoping for.

By August 2014, Serco announced that it was withdrawing from the NHS clinical services market altogether.

In early September 2017, **Primecare**, which had been awarded one of the first integrated NHS 111 and GP out-of-hours services contracts, announced that it would be handing back the contract to the NHS.

Initially this was to be in July 2018, but then in late September 2017 the company invoked a clause in the contract that meant it only had to give three-month notice.

After only seven months, Primecare was placed in special measures when its services in East Kent were rated "inadequate" by the Care Quality Commission. Failings included not assessing risks to patients' health and not having enough staff to meet patient needs.

Care UK terminated a contract to provide NHS GP out-of-hours services in April 2015. The contract was to provide care in conjunction with Portsmouth Health Limited (a group of local GPs), however the deal, which began in 2012, proved to be loss-making and so Care UK ended its involvement before the end of the contract. Similar tensions around cost-cutting were reported to be at the heart of the difficulties experienced by the out-of-hours company

Private companies are closing GP practices in areas where it is difficult to make a profit. In Brighton and Hove, **The Practice Group** announced in January 2016 that it will terminate its contract for five GP surgeries in the city at the end of June, leaving 11,500 patients looking for a new GP.

Over the years, The Practice Group, which runs around 50 GP surgeries, has also closed a surgery in Camden Road, London, the Maybury surgery in Woking, the Brandon Street practice in Leicester and the Arboretum surgery in Nottingham.

All these surgeries were in areas of high deprivation, where it is difficult to make money. The Practice Group defended terminating the contracts and closing services, saying that loss-making activities were unsustainable.

In late September 2017, the private ambulance company, **Private Ambulance Service** contracted to run non-emergency patient transport from hospitals in Bedfordshire and Hertfordshire went into administration, with trading ceasing 9 October 2017.

The business, which had 126 vehicles and employed 300 people, took over the contract in April 2017.

Problems had been reported with the service, including a report in the Herts Advertiser in July 2017 about Herts Valleys CCG issuing an apology after ongoing problems with the performance of the company, including leaving vulnerable patients stuck in their homes or in hospital for hours waiting for transport.

In October 2016, **Greenbrook Healthcare** announced its intention to hand back an APMS contract for five GP surgeries in west London nine months before the end of the contract. This put around 27,000 patients at risk of losing their GP.

Greenbrook had been in discussions with NHS England since early 2016, but no additional funding had been offered. The company stated that due to rising demand and problems with GP retention the contracts had become "unfit for purpose".

Private providers to be to be given say on £2 billion mental health budget

Plans to hand over millions of pounds worth of specialised commissioning for mental health, learning disabilities and autism to other organisations, including those in the private sector, have been outlined by NHS England.

According to HSJ, plans were outlined in a letter sent to chief executives of both NHS and independent sector providers.

The care model has been piloted since 2016 in 14 areas. It will now be rolled out across England, with a target of 75% by 2020 and all England coverage by 2022.

The new model involves the appointment of a lead provider who will be responsible for the budget and commissioning of services for a designated area.

It is part of the national project to "integrate" services, but the prominence of private providers in this sector raises the possibility of a commercial provider being given the lead provider role.

The lead provider will assume responsibility for commissioning functions, such as workforce planning and quality assurance, and thus control of a specialised commissioning budget of tens of millions.

The 2016 programme covered specialised commissioning of child and adolescent mental health services (CAMHS), adult secure care, and adult eating disorder services in 14 pilot areas.

The new plan will now also include learning disabilities and autism.

The new model of care in mental health is part of NHS England's push for integrated care and the development of integrated care systems and partnerships across England.

Tight-fisted new prescribing guidelines fail to make savings

Hannah Flynn

NHS England's latest attempt to reduce the availability of treatment to patients was ill-conceived and always doomed to fail.

Ever since the NHS founder, Aneurin Bevan resigned from cabinet over the introduction of NHS fees 1951, successive Governments have pushed against the principle that NHS treatment should be free at the point of use.

Experience around the world confirms that imposing even a relatively small charge is guaranteed to reduce the numbers of patients accessing a drug or treatment, especially the poorest, regardless of how much they might need the drug.

The latest attempt by NHS England to restrict GP prescribing of OTC medicines for 'self-limiting' conditions and make patients pay for medicines available over the counter (OTC), was recently revealed to have made just a quarter of the forecast £100m annual savings.

New pharmacy minister Seema Kennedy MP was forced to admit in a statement that spending on OTC medicines had not fallen as much as originally forecast.

Dr Andrew Green, BMA GP committee clinical and prescribing lead told ***The Lowdown*** the savings envisaged "were always ambitious, because GPs were already advising patients to buy over-the-counter medications where appropriate, but prescribing when they believed there was a need."

He questioned whether other savings had been made by avoiding GP appointments being made, but the statement by Ms Kennedy revealed no assessment had been made of this.

Pharmacists reported no increase in the number of OTC sales in the past year, according to trade publication Chemist+Druggist.

Sandra Gidley, chair of the English Pharmacy Board of the Royal Pharmaceutical Society commented: "In practice GPs have taken a very pragmatic view on [these prescribing guidelines] and appear to have carried on prescribing items if they believe the patient won't be able to buy the item."

"It would be interesting to see if there are differences in prescribing patterns between areas with minor ailments schemes and those without," she added.

While some common drugs like paracetamol can be bought more cheaply over the counter than on prescription, only with a prescription can patients access more than two days-worth of paracetamol, meaning that this is still useful to those required to take it daily, especially if they are entitled to free prescriptions.

Measuring Impact

Pointing patients to pharmacy services, as opposed to their GP practice has always been justified with the claim that it will free up GPs to deal with more needy patients. This can be the case, if alternative services adequately meet need. The minor ailments scheme for example, provides OTC drugs free for those who need them, without prescription.

Minor ailment schemes availability is patchy in England: however they are commissioned across Scotland and Wales, where prescriptions are already free. A PricewaterhouseCoopers report published in 2016 showed minor ailments schemes in England were worth nearly £50 million, nearly twice what NHS England's latest prescribing restrictions achieved.

So not only was it possible to save more money, it was possible to do so while ensuring treatment was free at the point of use. Most of these savings were from reducing GP appointments made by these patients.

This claim was further backed up by a study done across Scotland last year that demonstrated 85.9% of patients who accessed a pharmacy-based minor ailments scheme required no other NHS service, and just 6.4% of patients went on to see their GP.

A further study published in 2017 demonstrated the schemes were good at reaching those who needed them most, with just 8% of patients who used a minor ailments scheme in England saying they would have purchased the medicine over the counter if the scheme had not been available. Over half (61%) of consultations were for children under the age of 16, a group entitled to free prescriptions anyway.

"In practice GPs appear to have carried on prescribing items if they believe the patient won't be able to buy the item."

Unnecessary meddling

Interestingly, the All Wales Prescribing Advisory Group, an advisory body to the Welsh government withdrew its support for introducing similar prescribing guidelines in Wales, just days after the minister made her statement.

Does the existence of minor ailments schemes make the restriction of prescribing for OTC medicines unnecessary? The decision in Wales suggests some may think so. Either way, it is clear that any attempts to undermine the principle of providing treatment to NHS patients free at the point of use, will often result in driving up costs elsewhere.

Hancock's half-baked data – and the groups who provide it

Matt Hancock's appearance at a Taxpayers' Alliance (TPA) event last month raised eyebrows. As many on twitter rightly asked, why is the Health Secretary teaming up with a lobby group that has long wanted to do away a state-funded healthcare system?

Tamasin Cave investigates.

The TPA's latest report, Embracing technology in health and social care, for which Hancock wrote the foreword, marks a departure for the lobby group away from its usual demand for cuts. (Asked why the change in direction, its CEO said only "austerity is over, so...").

Instead the TPA report calls for more investment in technology and increased automation to save the NHS money. In this, it has joined an established network of lobbyists championing the idea that technology will save the NHS, each echoing the assertions of the last.

The TPA's figures, for example, are lifted from a 2018 report by the 'progressive' think tank, the IPPR, including its 'key finding' that the NHS could save £12.5bn a year through improved productivity from automation.

(The IPPR was quick to distance itself from the TPA, saying that it has 'twisted' its research and its proposals for the NHS were 'very different'. In truth, there's not much between the IPPR's press release last year and the recent TPA one).

Unexplained figures

Last year's IPPR's report came in for criticism, however, including in the BMJ, for showing 'no workings or figures, no appendices to explain how these extraordinary efficiencies were calculated'. So, where did the IPPR (and consequently the TPA) get its figures on the potential for technology to save the NHS billions?

From US management consultants, McKinsey. Tom Kibasi, the IPPR's current director was more than a decade at McKinsey where he led its work on 'innovative healthcare delivery', so perhaps this is no surprise.

The IPPR says the figures in its report, Better health and care for all: A 10-point plan for the 2020s, are the result of analysis of work by McKinsey on the potential for automation across industries, including healthcare.

They are not the only ones, however, to rely on McKinsey's number crunching when it comes to the promise of health tech.

Above: McKinsey-sponsored bright lights and full colour as Penny Dash (left) listens to Matthew Swindells getting ready to jump ship back to the private sector. Below, a gloomy room and empty seats for Hancock and the obscurely-funded "Taxpayers Alliance"

The firm has also produced similar for NHS England. An 'evidence summary' by McKinsey from 2014, which was released under freedom of information law, said that with a substantial investment in technology the NHS could achieve savings of between £8.3 billion and £13.7 billion.

NHS England's then national director for tech, Tim Kelsey – formerly of McKinsey – used the figures to call for the NHS to spend billions on embracing digital technology. McKinsey also provided the NHS with 22 recommendations to drive its adoption.

No evidence at all

The problem is that the figures McKinsey provided to NHS England, according to an academic in health information, were 'an educated guess'. "It's not evidence at all," Dr Philip Scott, a senior lecturer at the University of Portsmouth's Centre for Healthcare Modelling and Informatics, told Digital Health News having looked at McKinsey's summary for NHS England.

The suggestion that investment in technology could save up to £13.7 billion was "an unfounded claim", said Dr Scott. "It's not based on anybody actually having done it. It's based on what we think it ought to do." The potential savings had "the ring of being very optimistic estimates," he said.

Regardless, the message that digitisation and automation are the answer to the NHS's problems continues to be repeated without question, particularly in policy-making circles.

Just weeks before the TPA event, a day-long health policy conference in Westminster – sponsored by McKinsey – discussed the inevitability of technology 'transforming' healthcare.

Dash for technology

Penny Dash, a senior partner at McKinsey who has long been involved in market reform of the NHS, spoke alongside NHS England's outgoing deputy CEO, Matthew Swindell, who is rejoining the private sector. She explained how healthcare leaders can 'eliminate the roadblocks' to technological change.

Next month, Hancock will also be guest of honour at the annual health conference of the free market think tank Reform (funded by, among others, McKinsey). The topic of the conference? 'Unlocking the promise of digital health'.

For years, McKinsey has been a leading advocate for the use of more technology in healthcare, including the NHS.

It was involved, for example, in Tony Blair's £12bn NHS National Programme for IT, now know as the 'biggest IT failure ever seen'.

It was also involved in discussions around the NHS's doomed data-sharing project, Care.data, which was also eventually scrapped.

Driven by lobbying

Writing in the BMJ about his concerns with the IPPR report, David Oliver concluded that 'over claiming about technology' is more likely to be 'driven by industry lobbying, marketing [and] the financial bottom line', than by evidence.

Despite McKinsey's heavy involvement in the health service – in 2012 it was described as the 'firm that hijacked the NHS for its extensive involvement in Andrew Lansley's disastrous market reforms – it earns most of its money consulting for the private sector.

It has always refused to name its clients, but they are known to include some of the world's largest healthcare and drugs firms.

So, while we absolutely should demand to know who is behind the Taxpayers' Alliance and its recent lobbying for health tech, it's arguably more important that we know who else McKinsey works for.

Secret plans and dodgy figures in Leicestershire

John Lister

Secrecy surrounds recent development of NHS plans in Leicestershire. Local NHS bosses keep developing new flawed plans without ever learning the lessons of the previous ones. Now campaigners complain NHS chiefs are refusing to publish a key document: perhaps this is because after two previous failures they know it cannot withstand public scrutiny.

Leicester, Leicestershire and Rutland (LLR)) has just one acute hospitals trust, University Hospitals of Leicester (UHL) on three sites: for many years there have been plans to reduce this to two, with the loss of acute beds and services at Leicester General Hospital.

Proposals for this, running alongside cutbacks in community hospital services – predate NHS England's ***Five Year Forward View*** in 2014. By summer 2014 the optimistically-named LLR "Better Care Together" project ("a partnership of Health and Social Care") had already published its Five Year Strategy, followed in December by a "Strategic Outline Case". This insisted that:

"the path laid out in the five year strategy is ***the only way of achieving clinical and financial sustainability***" (p9).

It took less than two years to prove this, and much of the document, wrong.

The SOC had bravely promised to produce a series of business cases, which would apparently involve working through plans "in granular detail". None have yet appeared.

Vague

Most proposals other than the precise number of beds to close, were vague: key to the SOC was a "left shift," to care delivered outside of hospitals: "a vision for the future in which the community model of care is transformed, with far more provision of care taking place outside hospital in primary, community and home care settings." (p10)

There were neither concrete proposals nor the necessary investment to expand community and primary care services to take on the extra work. Nonetheless the SOC anticipated that these changes would lead to:

"the reduction of 427 beds at UHL [24% of the total of the trust's 1773 day and overnight beds], and allow the organisation to achieve its vision of moving from 3 to 2 acute sites by 2018/19, a core strategic objective." (p10)

The SOC's almost incoherent "Bed reconfiguration summary" went further, and argued the need to reduce UHL bed provision by an even higher number:

"In total, actions need to be taken across LLR to remove 571 beds from UHL. This is made up of:

UHLs detailed bed reduction

Figure 47: Profiled bed reductions

Year	Physical beds reduced
15/16	203
16/17	122
17/18	61
18/19	41
Total	**427**

Figures from the STP

"462 beds related to UHL efficiency reductions and left shift of sub-acute patients …

"109 beds related to workstream efficiency reductions. Overall, this will mean that UHL's bed base will reduce by 427 beds because some of this reduction is required to reduce anticipated activity growth over the five years of the plan." (p70)

The SOC promised to produce a series of business cases, which would apparently involve working through plans "in granular detail". None have yet appeared.

The assumptions underlying this massive, sustained reduction in acute bed numbers at a time of increasing demand for health care were in the realm of fantasy:

"UHL and LPT [Leicestershire Partnership Trust] have agreed that 250 beds worth of patients can be cared for outside of an acute setting. The 250 beds are broken down as follows:

"170 where patients can be treated by expanded community teams;

"80 "sub-acute" beds, where patients need to be treated in an existing community hospital bed, with enhanced home care support." (p71)

However the same plan, on the same page, also proposed to ***cut*** 87 community hospital beds – reducing LPT from 660 beds to 573 (p71). The plan's authors hoped patients could be looked after ***in their own homes***, by miraculous means:

"Services will be expanded **to enable patients to be cared for in their own homes** (equivalent to 250 beds worth of current activity, 170 direct from the current UHL activity and 80 from the existing community hospital activity)." (p90, emphasis added).

Unrealistic

The SOC was unrealistic from the outset. One problem was hugely inflated claims of a massive financial gap. According to SOC projections in 2014:

"The total gap between income and expenditure for the NHS element of the LHSCE [Leicestershire Health and Social Care Economy] in 2018/19 is £398m before any CIP/QIPP or other projects are modelled." (p10)

With a gap that big it was impossible to propose plausible policies to deal with it.

Two years later, in 2016, in an even worse financial situation, NHS England called for Sustainability and Transformation Plans to be drawn up in 44 new "footprints" across England. The LLR footprint plan came up with more bizarre and unexplained statistics and assumptions.

The assumptions underlying this massive, sustained reduction in acute bed numbers at a time of increasing demand for health care were in the realm of fantasy

Despite claiming almost exactly the same spending gap as the SOC two years earlier, the STP outlined a plan to cut a much smaller number (243) acute beds (13%) from a claimed total of 1,940 (p5). This made no sense. Department of Health figures showed a very different total number of beds for that year – just 1,665 (including day care beds). Leicestershire by this measure already had 32 beds fewer than the STP was seeking to cut back to by 2020.

The STP still proposed at the same time to cut community beds by 16% (38). Yet there were no serious plans to establish or resource the "intensive community support" or "integrated teams" envisaged in the STP (p33).

Wishful thinking

It all seemed like wishful thinking. STP reductions for acute and community beds were significantly smaller than the 2014 proposals, but equally unrealistic.

The hopes that diverting large numbers of patients away from A&E and avoiding the need for hospital treatment and thereby allowing hospital beds to be closed have proved unfounded. The pressures on front line services have increased. Only once since the spring of 2017 has UHL even managed to see and treat 90% of A&E patients within 4 hours: most of the time performance has been below 75%, despite the openeng of a brand new A&E facility. Even during the relatively easy winter of 2018/19, waiting times remained abysmal.

Indeed far from being able to close beds and care for patients at home, UHL core acute bed numbers have remained largely unchanged since 2014, with a significant (90%) increase in day only beds: bed occupancy across the relatively mild 2018/19 winter and for most of the year was routinely above 90%, leaving no scope for bed reductions.

Without the bed closures, the huge cash savings hoped for in the STP have not materialised either: the most recent financial report to the UHL trust board shows that it was £31m adrift from its optimistic 2018/19 aim of delivering a £29.9m deficit (which would have resulted in a £0.8m surplus after support payments). This failure resulted in the loss of "provider sustainability funding" – and an end of year situation £50.3m worse than planned.

Campaigners' challenge

One reason local services have remained largely intact has been the consistent challenge by local campaigners. The Campaign Against NHS Privatisation, and newly formed Save Our NHS Leicestershire along with the Leicester Mercury Patients Panel have staged demonstrations, held public meetings, drafted responses, tabled Freedom of Information Act requests, submitted questions, lobbied and briefed local council bodies and MPs.

A hard-hitting critique of the STP by local campaigner Sally Ruane was published by De Montfort University in 2017, and a successful intervention by campaigners later that year effectively derailed plans to move towards setting up an Accountable Care System with no consultation.

In the summer of 2018 campaigners published an even more detailed renewed challenge to plans to relocate Intensive Care (ICU) beds out of Leicester General. The proposal had been pushed through with virtually zero scrutiny and no consultation back in 2015 on the grounds that it was urgent: but three years later it still had not been carried out.

LLR STP's yellow brick road that bears no relation to reality

The reasons for campaigners' concern was that it represented a major first step in downgrading Leicester General, and that it would also disrupt three specialist services for an indefinite period. Vital technical details had not been made publicly available, and even after three years CCGs had still failed to consult the public.

We have already noted the variance between successive plans for bed cuts in acute and community hospital.

How many beds are there?

A campaigners' Briefing Paper for local MP and shadow health secretary Jon Ashworth completed earlier in 2019, notes a new, even higher claimed figure for numbers of UHL beds: 2,045 beds if we believe a Trust response to an FOI request in May 2018, or 1,992 beds according to two trust executives in meetings six months later.

Both of these figures are much higher than official NHS figures for UHL bed numbers, the most recent of which was 1,874 (including 216 day case beds).

Nor is there any consistency on claims for how many patients could be cared for out of hospital: "One UHL spokesman stated 15% of patients currently in UHL beds did not need to be there; another spokesman stated 30% of patients in UHL beds did not need to be there."

Some of these questions might be answered if the Trust, who are seeking £367m to reconfigure their acute services, would only publish a pre-consultation business case (PCBC) which they said last November they were about to send to the NHS investment committee for consideration.

Campaigners have been led to believe the PCBC is a very substantial document (although on previous record, size does not equate to quality). But six months on, despite repeated requests to see and discuss it, it is still being determinedly kept under wraps, allegedly at the urging of NHS England.

More than five years of slipshod planning, secretive processes, evasions of consultation and inconsistent documents give local people in LLR no reason for confidence in the Better Care Together project or the team running it. The longer the PCBC is kept secret the less credibility NHS bosses have with their patients and public.

Campaigners are now calling on local politicians to step up and add their weight to the demand for transparency. Previous schemes drawn up without consultation have proven to be deeply flawed: the danger is that NHS trusts and commissioners are again headed down this same dead end.

"One UHL spokesman stated 15% of patients currently in UHL beds did not need to be there; another spokesman said 30%"

Health tourism: serious problem or tabloid creation?

The Daily Mail and the Express have reported this week that the Government has shelved its plans to crackdown on health tourism, amid accusations that "MPs have caved in to left wing doctors" - so what are the facts?

Pilot schemes have been running at 18 hospitals, introducing charging into some community services, with NHS Trusts having a duty to check the eligibility of all patients before providing treatment in hospital, including many in London.

The schemes, which were begun following an expansion of regulations in October 2017 have now been abandoned after continuous campaigning and complaints about the impact of the policy. Some patients were being asked to pay upfront or risk being turned away.

At the end of April, the Guardian reported on the death of an anti-FGM campaigner and asylum seeker from Gambia, known as Saloum, who was diagnosed with terminal cancer after collapsing in the street last December. Following initial NHS treatment he was sent away because he was not eligible for free NHS care as an undocumented migrant.

However, the charity Doctors of the World, argued that treatment for his cancer was urgent and immediately necessary, which under the regulations should have meant he was treated. Eventually he was given some treatment at the University Hospitals of Derby and Burton NHS foundation trust.

Other stories include a woman with advanced breast cancer denied potentially life-saving therapy for six weeks and one of the Windrush generation, who was denied NHS radiotherapy for six months due to uncertainty over his immigration status.

Campaigns spearheaded by groups such as Docs not Cops have questioned the effectiveness and safety of the pilot schemes. Action by campaigners prompted England's biggest NHS trust, Barts Health, to stop photo ID checks and remove posters warning: 'NHS hospital treatment is not free for everyone.'

What do the figures say?

In May 2018, the Evening Standard reported that figures from London hospitals found that of 8,894 people asked for two forms of ID prior to treatment only 50 actually had to pay for their care.

Media outlets, such as the Daily Mail and The Express, have stated that 'health tourism' costs the NHS £280 million, but there is no reliable evidence to support this figure.

The organisation Full Fact last looked at the figures for health tourism in 2016 and noted that any estimate will be very rough. All the figures used by Full Fact and other organisations come from a 2013 Government report.

The 2013 report estimated that ineligible people cost the NHS almost £2 billion a year, but those that possibly fall into the category of 'health tourist' cost the NHS £100 to £300 million a year or 0.3% of annual health spend.

The report makes it clear that it is extremely difficult to calculate a health tourism figure and that it can only provide a rough estimate. Two reasons why;

- Firstly, it is very difficult to track patients who are not eligible to use the service as no charge is made for GP and emergency services.

The 2013 report estimated that 'health tourists' cost the NHS £100 to £300 million a year or 0.3% of annual NHS spend

- Secondly, there are flows in both directions. The UK creates its own health tourists from people who move to Europe but then come back to the UK to use the NHS, including seeing a GP for repeat prescriptions.

Although the pilot checking schemes seem to have been abandoned, the regulations put in place in the Immigration Act 2014 are still in place. The Act expanded the group of people who can be charged and introduced an 'immigration health surcharge' for those seeking visas to enter the UK, and a charge of up to 150% of the cost of treatment in hospital.

Reaction to the scheme

Groups, such as Docs not Cops and Doctors of the World, say the regulations have created considerable problems - wasting considerable time and money on checking and caused extensive human suffering.

These groups are not alone in condemning the regulations, but despite this at the end of 2018, Secretary of State for Health & Social Care, Matt Hancock stated that "there is no significant evidence that the 2017 amendment regulations have led to overseas visitors being deterred from treatment or that the changes have had an impact on public health".

As a result of his statement in December 2018, the Royal College of Physicians, the Royal College of Paediatrics and Child Health (RCPCH), Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Public Health (FPH) called upon the Department of Health and Social Care (DHSC) to suspend the charging regime (NHS Charges to Overseas Visitors) (Amendment) Regulations 2017, pending a full independent review of their impact.

Docs not Cops and Doctors of the World say the regulations have wasted considerable time and money and caused extensive human suffering

Evidence withheld

The only evidence of the impact of the regulations comes in three reviews conducted for the DHSC: but none of these reports has been made public.

In March 2019, MPs, Royal Medical Colleges, leading academics, healthcare professionals and unions wrote to Matt Hancock, calling for the publication of the three migrant healthcare policy reviews.

These reviews looked at the impact of the controversial policies, including withholding healthcare from migrants who cannot pay in advance. The letter claims the reviews received "evidence of deterrence and serious harm" caused by these policies "which we consider to be of the utmost seriousness".

In an effort to help migrants and other groups caught in the confusion of the regulations, at the beginning of May, the organisations Docs not Cops, Medact and Migrants Organise, launched Patients Not Passports, an online toolkit "to support individuals to advocate for people who face towering advanced payments ahead of accessing NHS care, and to end immigration checks on those suspected of being "overseas visitors"".

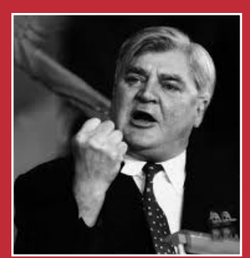
The toolkit contains resources, such as who exactly is exempt from charges and aims to help end the confusion surrounding the regulations, which has led to delays to treatment.

Over the past year or so there have been numerous media reports of delays in NHS care for cancer patients in particular. Although few in the UK are affected by the regulations, as the organisation Docs not Cops notes, they could have a huge impact on us all and on overall public health; if people with infectious diseases are too scared to visit GPs due to irregular immigration status then this could be serious for society. They may wait until the disease worsens leading to much bigger problems in the long run.

Docs not Cops says the regulations represent a complete dismantling of the NHS' founding ideals that "it be based on clinical need, not ability to pay."

What Aneurin Bevan said about health tourism

(from In Place of Fear, 1952)



"One of the consequences of the universality of the British Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes.

No doubt a little of this objection is still based on the confusion about contributions to which I have referred. The fact is, of course, that visitors to Britain subscribe to the national revenues as soon as they start consuming certain commodities, drink and tobacco for example, and entertainment. They make no direct contribution to the cost of the Health Service any more than does a British citizen.

However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors?

For if the sheep are to be separated from the goats both must be classified. What began as an attempt to keep the Health Service for ourselves would end by being a nuisance to everybody.

Happily, this is one of those occasions when generosity and convenience march together.

The cost of looking after the visitor who falls ill cannot amount to more than a negligible fraction of £399,000,000, the total cost of the Health Service. It is not difficult to arrive at an approximate estimate. All we have to do is look up the number of visitors to Great Britain during one year and assume they would make the same use of the Health Service as a similar number of Britishers. Divide the total cost of the Service by the population and you get the answer.

I had the estimate taken out and it amounted to about £200,000 a year. Obviously this is an overestimate because people who go for holidays are not likely to need a doctor's attention as much as others. However, there it is. for what it is worth and you will see it does not justify the fuss that has been made about it.

The whole agitation has a nasty taste. Instead of rejoicing at the opportunity to practice a civilized principle, Conservatives have tried to exploit the most disreputable emotions in this among many other attempts to discredit socialized medicine.

Naturally when Britons go abroad they are incensed because they are not similarly treated if they need the attention of a doctor. But that also I am convinced will come when other nations follow our example and have health services of their own."

What the (research) papers say

Lessons from last winter's crisis

John Lister

This recent BMA overview of the experiences, performance and lessons from the winter pressures on the NHS in 2018-19 is a valuable and readable resource accessible to all, although it only focuses on acute care and does not discuss equivalent pressures on mental health.

Just 22 pages long, NHS Pressures – Winter 2018/19 A hidden crisis collates a very useful range of information sources in its bibliography at the end, and breaks the winter crisis down into bite sized and easily recognised chunks.

Perhaps even more important an overview final section 'How can we relieve pressure on the NHS?' sets out a series of positive proposals for doctors, trade unionists and campaigners to take up with MPs and with national and local NHS chiefs.

One notable feature from the outset is the significant (6%) increase in demand for emergency care despite almost three decades of assurances and assumptions by ministers and NHS chiefs that it would be reduced by alternative services outside hospital.

The study makes clear the inadequate number of beds: average bed occupancy this winter was 93.5%, and 41 trusts (of 134) recorded bed occupancy of 100% on at least one day.

Despite clear calls from the Royal College of Emergency Medicine and the BMA last winter for more beds to be brought on stream, the total number of beds across NHS England was consistently down on last year's numbers.

Cancer care was also delayed in most trusts, with almost 70% of providers missing the target for 85% to be treated within 62 days of referral in both January and February.

Although there is no comparable level of detailed data on primary care the report shows GP appointments involving a wait of over two weeks were up 13% on last year.

The conclusions highlight under-funding ("health spending in the UK would have to be increased by £9.3bn for the year 2019/20 in order just to draw level to the EU countries' average health spend of 10.1% of GDP"] the need for more beds and for improved data all year round on beds and much more data on primary care.

The paper does what it says on the cover: it may have surprisingly little to say on staffing, and it is not by any means a full manifesto for change, but it does bring together the data we can use to compare further winters to come.

THE lowdown

Who we are – and why we are launching *The Lowdown*

The Lowdown launched its first pilot issues and a searchable website in February 2019.

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

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

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

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

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

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

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

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

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

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

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

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

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

Why is it needed?

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

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

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

In our first year we will:

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

Help us make this information available to all

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

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

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

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

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

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

On the website we will gratefully acknowledge all of the founding donations that enable us to get this project off the ground.

- Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG
- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at contactus@lowdownnhs.info