THE lowdown

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

Bradford 97% vote for strike to stay NHS

Over 200 UNISON members at a Bradford Teaching Hospitals Foundation Trust – 97% of those voting – have voted to take strike action next month amid fears over "backdoor privatisation" of some of its services.

UNISON balloted its 313 affected members after the Trust unveiled plans to set up a wholly owned subsidiary company – securing a 70% turnout, and recruiting another 37 members.

The Trust plans to transfer around 600 staff from its estates, facilities and clinical engineering departments into the new company, but denies it is privatising services.

UNISON Regional Organiser Natalie Ratcliffe was clear:

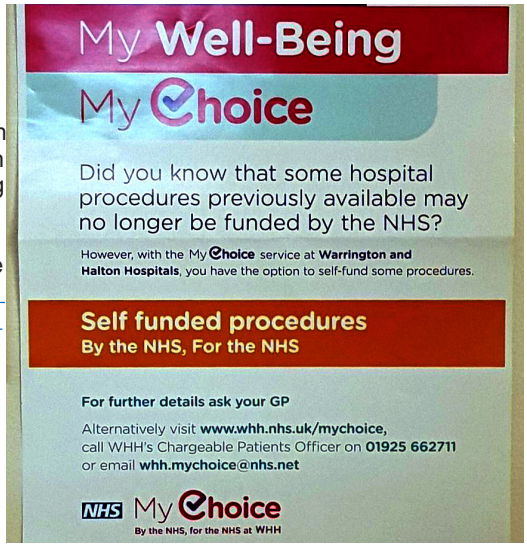
"This sends a clear message to the Trust that members are angry about these proposals. They clearly want to stay employed within the NHS to ensure they retain NHS conditions of service - and

(cont'd page 2)

Warrington warning

John Lister

Under the supremely inappropriate label of "My Choice," Warrington and Halton Hospitals Foundation Trust has decided to cash in on frustration at the growing list of treatments excluded from the NHS by cost-cutting CCGs in Merseyside and Warrington, and launch its own private NHS patient service.



There are fears that this is the increasingly commercial face of the NHS that is emerging from almost a decade of austerity on funding, and six years of legislation that urged Foundation Trusts like Warrington to make up to 50% of their income from private medicine.

Patients whose painful and debilitating health problems are now branded as "Low Clinical Priority" by commissioners, despite their proven value, can now nonetheless purchase the operations for cash up front from an NHS trust, which congratulates itself on its "affordable self-pay service," which charges "the local NHS price, previously paid for by commissioners."

Now – just as it was before the NHS was founded – patients who can afford it are urged to stump up the cost of treatment themselves, while for the many who can't there is not even a shrug.

The trust's website boasts that whereas My Choice was originally created in 2013, "the service has been significantly extended to include the large number of procedures no longer available on the NHS". It obligingly offers an extensive price list, including Hip replacements at £7,050; Knees at £7,179; and Cataracts at £1,624 each; as this is finalised the Mirror has just found an additional price list quoting up to **£18,000** for a hip operation.

Chief executive Mel Pickup says: "Procedures of low clinical priority do not mean low value to our patients, and we are pleased to be able to make a large number available at a really affordable price, at their local hospitals."

But this is not a Private Patient Unit. Patients are warned not to expect any special treatment: they are simply paying for NHS treatment that was once free.

"There are no private rooms and they will join the same waiting list as NHS patients. The major benefit is access to outstanding NHS treatments at a fraction of the cost of those undertaken by private providers."

It may not be long before other NHS trusts in the area and elsewhere in the country are following the Warrington model, excluding large numbers of elective treatments from the NHS for those without the money to pay.

The same long list of 71 excluded services has been imposed by **all seven** CCGs in Merseyside and Warrington, under the pretext of helping to "reduce variation" of access to NHS services in different areas ("sometimes called 'postcode lottery' in the media") and "allow fair and equitable treatment for all local patients."

To promote this massive shrinking of NHS cover as "My Choice" adds insult to injury.

Anyone accessing the service would choose for the NHS to pick up the tab rather than fork out themselves, and be told that by paying out thousands of pounds they are enabling the Trust to "make use of spare capacity and generate additional income to support our other services."

Campaigners are urging local MPs to step in and hold the CCG to account, and call for normal NHS services to be resumed.

Questions also need to be asked of the Trust's board of governors whose sanction is needed before such policies are implemented – and the so far silent NHS England and Health Secretary Matt Hancock, on why they are conniving at, or driving such an erosion of the NHS.

IN THIS ISSUE

Has NHSI given green light for more WOSs?

John Lister

The new round of proposals by NHS trusts and foundations to launch "wholly owned subsidiaries" comes after a series of strikes and battles last year challenged and defeated similar moves, most conspicuously at Wrightington Wigan and Leigh FT, where a succession of strikes eventually forced a change of policy.

In the late summer NHS Improvement, seeking to avoid further bruising clashes, announced there would be a review of the guidance issued to trusts on how to carry out such changes, and urged a pause in any further creation of subsidiaries.

By November, fresh guidance was published, which was seen by the unions as putting fresh hurdles in the way of trusts seeking to hive off their staff. The document stated that it was outlining

"a new framework that changes the way subsidiaries are reported to and approved by NHS Improvement from 26 November 2018."

But it also rather ominously went on:

"This framework strikes a balance between assuring us [NHSI] and respecting NHS freedoms and the ability of the NHS to innovate."

Indeed the tone is almost apologetic:

"We recognise that this updated approach increases the regulatory burden on some providers and we commit to reviewing the approach after one year to consider whether it is still appropriate and proportionate." (1.3)

The focus of the new guidance was on the obligation of each trust to produce a convincing business case, which "must demonstrate to the Secretary of State that the subsidiary is income generating" (1.2). Up to now business cases have been of poor quality, and little more than flimsy fig-leaves to conceal a hope of escaping VAT costs by establishing companies that can claim exemption.

The powers of trusts to set up such companies are based on legislation and guidance brought in by the New Labour government back in 2006. This stipulates that an income generation plan

■ must be profitable and provide a level of income that exceeds total costs…

The fact that new proposals are being pushed forward now, suggests the plans have been rubber stamped by Matt Hancock.

■ the profit made from the scheme … must be used for improving the health services

■ and the goods or services "must be marketed outside the NHS."

The guidance emphasises that "[Services] being provided for statutory or public policy reasons are not income generation" …

"the general legal power of NHS trusts to do anything that appears necessary or expedient in connection with their functions does not allow them to form or participate in companies for the purposes of core NHS healthcare provision. Trusts should not seek legal advice at the public expense on this issue." (2.1)

It also refers to more recent DHSC 2017 guidance and Treasury advice which make clear that:

"tax avoidance arrangements should not be entered into under any circumstances. We expect all NHS providers to follow this guidance when considering any new arrangements or different ways of working. … trusts should not spend money on private sector consultancy support in the development of tax avoidance arrangements as this represents active leakage from the healthcare system."

However the NHSI guidance is very tentative in spelling out what will be done where these principles appear to be breached. In lesser cases, "we request evidence in the form of a certification that the parent trust board has satisfied itself in relation to key areas of risk." This certification "should be submitted to and agreed with us before the trust enters into any legally-binding arrangements in relation to the subsidiary transaction."

Weak language like "requests" and "should be" implies little commitment to restricting trusts' actions.

In more serious cases "we undertake a further detailed review".

Despite the weak language it is clear that creating subsidiary companies currently requires the consent of the Secretary of State. And if the NHSI review panel rates the risk of a proposal as Red rather than amber or green "we can use our regulatory powers to stop the transaction if required" (p12).

So the fact that three new proposals are being pushed forward now, despite the opposition of staff, suggests NHSI has given them a green or amber light and the plans have been rubber stamped by Matt Hancock.

The government and NHSI have not learned the lessons of last year's strikes and confrontation – and are headed for more, similar confrontations – yet again making a nonsense of NHS England's rhetoric earlier this year about "integration" and seeking to scrap the sections of the 2012 Act which require competitive tendering.

Action against hiving off support staff

(Continued from front page

remain part of the NHS 'family', as the Trust describes its employees."

"The Trust have said they will guarantee that these members will have their pay and conditions for up to 25 years. Our members see that this is a promise that can be very easily broken."

Meanwhile in Birmingham, about 40 NHS porters, housekeepers, domestic assistants and maintenance staff at Birmingham and Solihull Mental Health Foundation Trust, who face being transferred to a wholly owned subsidiary (WOS) will strike for three days on 24-26 June after a 92% vote for action against being transferred to Summerhill Services Ltd from 1 July.

Unite regional officer Frank Keogh said: "This unpalatable transfer will strip our members of their status as NHS employees and is a part of the accelerating backdoor privatisation of the health service. Ultimately, it will lead to salami slicing of patient services. Unite is disappointed that trust bosses want to push ahead with their plans, despite the overwhelming opposition of the workforce.

"We are strongly against the formation of these entities which, we believe, could lead to a Pandora's Box of Carillion-type meltdowns – with adverse knock-on effects on patient services and jobs."

About 1,000 NHS housekeeping, estates management, equipment maintenance, catering, procurement and security staff at Frimley Health NHS Foundation Trust could also face being transferred to a wholly owned subsidiary (WOS). The Frimley trust provides NHS hospital services for about 900,000 people across Berkshire, Hampshire, Surrey and south Buckinghamshire.

More beds are needed - Stevens

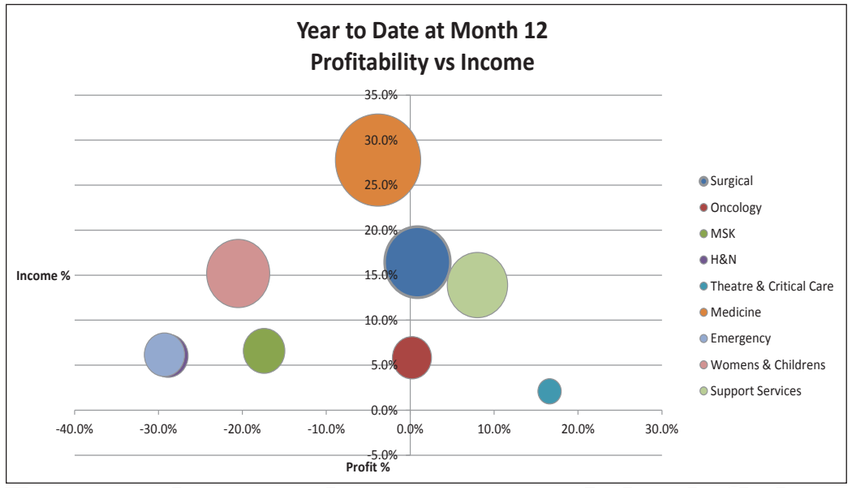
After more than a decade of relentless pressure to reduce numbers of front line hospital beds there was a first glimmer of common sense from NHS England chief Simon Stevens speaking at the NHS Confederation conference on June 19.

According to the HSJ report, Stevens finally stated openly that NHS hospitals' bed stock was "if anything, overly pressurised" and in need of "increased capacity".

The change of line at the top follows lobbying from NHS Providers, the trusts' most energetic advocates, and from professional bodies including the Royal College of Emergency Medicine which has seemed to be ploughing a lone furrow in raising this demand.

However accepting the need for more beds is a long way from delivering any increased number of beds, especially given the desperate shortage of NHS capital, highlighted again this month by NHS Providers (See aso page 5).

And a change of line by NHS England does not guarantee any change of attitude from bone-headed CCGs whose commissioning decisions have been one of the factors driving the reduction in beds since 2013.



Trust paints a picture to explain deficits

Unusually revealing figures in the end of May Board Papers for the troubled Shrewsbury and Telford Hospitals trust make clear that the trust as a whole is running at a loss:

"At month 12 the overall profitability for the Trust was 7.25% loss."

This cryptic comment is followed by a bubble chart, placing coloured bubbles that show the relative size of income from various specialist services on a scale that ranks them according to whether the service is profitable or loss making.

Medical specialities are by the largest loss makers with the bulk of services running up to 10% in the red, although women's and children's services are another large specialist area running even deeper in the red zone, with deficits of 15-25%.

Emergency services, a relatively small portion of income, generate a higher level of loss, with costs of delivering the service outstripping the tariff payment by around 30%. Musculoskeletal services run at a 15-20% loss.

Cancer services appear divided down the middle with half losing and half in surplus, surgery is two thirds in the profitable zone, but delivering no more than 5%.

Theatre and critical care services deliver consistent surpluses of 15-18%, but are small in scale.

So overall it's clear that this hospital trust would not be a going concern anywhere other than in the NHS. Two obvious conclusions:

● trusts like this will never be seen by US health corporations as potentially profitable targets to take over:

● and trust deficits are driven by serious underfunding of these core services – and they cannot be ended without brutal cuts in core services that would inevitably cause a major public outcry.

Hancock to face the music on charges

Matt Hancock has been summoned to appear before the Commons Health and Social Care Committee to explain his refusal to provide it with information.

The Committee is keen to make its own assessment of the Government's review of NHS overseas visitor charging. Back in January, it wrote to Hancock asking to see a copy of the review of amendments made to the NHS Overseas Visitor Charging Regulations in 2017.

Then Health Minister Stephen Hammond had made a written statement on this before Christmas, but the Committee had not seen the full review or the evidence provided to it.

Hammond's statement claimed that the review showed "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".

The Committee wanted to make its own judgement on whether or not this was the case.

However Hancock's reply argued that he could not publish the review or the evidence because they contained "confidential information" from "interested stakeholders" which was submitted on the basis it would not be published.

Hancock has now been "invited" to account for his refusal to provide the information. It seems like an invitation he can't refuse.

The Committee responded requesting the evidence be supplied in confidence, along with the report, and offered to consider what sections might need to be redacted if it were published

Once again but Hancock refused to supply the information required.

The Committee has now states that it considers this refusal to be "contrary to the Government's commitment to being "as open and transparent as possible" with select committees", and in violation of the "presumption that requests for information from Select Committees will be agreed to".

Hancock has now been "invited" to give evidence in person on Tuesday 25 June, to account for the refusal to provide the information. It seems like an invitation he can't refuse.

And with the government claim so much out of kilter with the Royal College of Physicians and many medics and health professionals arguing the negative effects of the Charging Regulations, it seems likely he will have a hard time persuading the Committee that the 'review' was not just a cosmetic exercise.

NW London plan for mega CCG – ignoring local needs of 2.2 million people

John Lister

Just weeks after Health Secretary Matt Hancock and NHS England finally scrapped their long-running efforts to reconfigure hospital services and close Ealing and Charing Cross Hospitals, North West London health chiefs might sensibly have stayed quiet for a while, or even better offered an apology to local people for the money and effort wasted since 2012.

Instead they have already floated another unpopular plan.

This time they want to merge all eight CCGs in NW London into one mega CCG covering 2.2 million people and a patch stretching from Heathrow Airport to the middle of London, and from Putney to the M25.

The very notion of this as being in any way "local" or responsive to communities within this large area is laughable. It is very different indeed from the verbal commitment to localism that was used to sell the 2012 Health and Social Care Act, which set up the CCGs, and remains the legal framework of the NHS.

In fact it seems that a major attraction of the merger is likely to be hopes of being able to push through controversial plans by outvoting any CCGs and local boroughs which disagree, as NW London health chiefs tried to do with their "Shaping a Healthier Future" (SaHF) project until it was belatedly killed off.

Even at a time when other CCGs have been merging, its 2.2 million population would make NW London CCG an enormous monster, with more than double the population of the Devon CCGs that merged last year, and 1 million more than Birmingham and Solihull.

The paper arguing the case for the merger predictably cites the NHS Long term Plan, which vaguely called for each Integrated Care System to relate to a single CCG.

NHS England guidance

But it conveniently ignores specific NHS England guidance on CCG mergers that has been published since the Long Term Plan, and it's plain to see from the characteristically evasive language they use that the CCGs cannot answer many of the key issues raised in that guidance.

The guidance stresses that NHSE alone has the power to agree or reject an application for a merger, and there is no right of appeal. It is supposed to seek evidence on the extent to which the proposers have has sought the views of local authorities and other relevant bodies, "what those views are, and how the CCG has taken them into account". (p8)

In addition NHS England calls for evidence on

"the extent to which the CCG has sought the views of patients and the public; what those views are; and how the CCG has taken them into account;"

Since the track record of NW London CCGs on seeking and taking on board any critical views from local authorities or the public was appalling throughout the long-drawn out effort to push through SaHF – for which they have still not apologised or been called to account – there is little reason to suppose they will do any better now.

A major attraction of the merger is likely to be hopes of being able to push through controversial plans by outvoting any CCGs and local boroughs which disagree

Indeed the insistence on pushing through those plans led to two of the eight boroughs, Hammersmith & Fulham and Ealing, refusing in 2016 to support the Sustainability and Transformation Plan which mirrored the SAHF proposals.

That's why on page 6 of the document the CCGs state that the health and care system in NW London comprises 30 organisations including only six local authorities. On page 8 they concede that the area includes eight local boroughs. However at no point is this discrepancy discussed: instead the document claims evasively that the NHS

"will need to be clear about the strategic role of the integrated care system, operating at NW London level, and how we will work with our local authority partners in integrated care partnerships at borough level." (p8)

Councils left out?

Are Hammersmith & Fulham and Ealing included as "local authority partners" – or ignored?

The document predictably argues that a mega-merger could save money on admin costs, while downplaying any possible loss of jobs for CCG staff and claiming that they would retain "a strong and visible local representation in each borough".

But given that the entire operating cost of all eight CCGs is admitted to be no higher than £5.4m a year, £680,000 per CCG, even scrapping all of them completely would save just 0.2% of NW London CCGs' £2.9 billion combined budget. If this microscopic saving comes at the expense of any real accountability to local communities it's a poor trade-off.

There are many more weaknesses that could be highlighted in the 24-page document: but the biggest flaw of all is that it fails to address any of the key questions raised by NHS England's guidance, which states (page 10):

"The existing CCGs must demonstrate how the merger would be in the best interests of the population which the new CCG would cover. This is particularly important in any case where the boundary of the proposed new CCG is not coterminous with local authority boundaries.

"In all cases, in line with the legal requirements, the existing CCGs must demonstrate in their application that they have effectively consulted with the relevant

Will NW London CCG merger leave out both Ealing and Hammersmith & Fulham councils?

local authority(ies) regarding the proposed merger, record what the local authority(ies)' views are, and what the CCGs' observations on those views are. "They should also show how they have/will put in place suitable arrangements with local authorities to support integration at 'place' level (population of between 250,000 and 500,000)."

Nor do the CCGs appear to have answers to questions they themselves raise in the document, such as:

- What safeguards would a single CCG need to ensure it was responsive to local needs?
- What considerations should there be about a single CCG governance arrangements?
- How do we get a strong public voice into a CCG at NW London level?
- How do we ensure that the local voice is strengthened?
- The local partnership between health and local authorities will be key to delivering the outcomes the NHS Long Term Plan – how do we ensure this is most effective?
- What level of integration is appropriate and achievable? (p12)
- How will we engage with patients/public at local level?
- How would patients and residents be involved in decision-making?
- How should we maintain local accountability?" – p15
- How can we maintain staff morale and retention through this period of change? (p17)

How indeed? With more questions than answers, and a track record of indifference to local views, it would not be surprising if a groundswell of opposition to this merger plan emerged in NW London – inspiring similar challenges elsewhere, including the equally half-baked plans across the river to merge six South West London CCGs into one.

Cash cuts make a nonsense of NHS Long Term Plan

John Lister

The NHS Long Term Plan published just six months ago is already in shreds, undermined by impossible targets, the chaos in government and the continued austerity squeeze on both capital and revenue budgets.

The plan contained over 60 uncosted commitments to service improvements: but now the possibility of implementing any of it has been thrown into question, with unanswered questions over capital and revenue funding. It noted, for example that:

"The NHS will use its capital settlement to be negotiated in the 2019 Spending Review in part to invest in new equipment, including CT and MRI scanners, which can deliver faster and safer tests." (p57)

The case for such improvements is clear. After decades of under-investment Britain has the lowest level of provision of such crucial diagnostic equipment of any comparable advanced economy. But the promised changes are again on hold.

First the HSJ revealed a letter to trusts in May, telling them to cut down the scale of their requests for capital funding – and therefore also constrain the scale of any new developments or facilities. Trusts were being too ambitious in their plans, reflecting "pent up demand for capital spending," and "This level of capital spend would lead to the NHS unacceptably breaching its capital spending limit…"

Limit FT spending

NHS England and NHS Improvement were also seeking legal powers to limit capital spending by Foundation Trusts.

This followed warnings in March by the Health Foundation that annual capital spending in NHS trusts had fallen by 21% between 2010/11 and 2017/18 (see The Lowdown pilot issue #4). An increasing share of this was being frittered away propping up revenue budgets rather than invested, along with money from sale of assets:

"In 2017/18 almost two-thirds of the proceeds from land sales went into the revenue, rather than capital, budget." (p12).

Then in early June Liz Truss, chief secretary to the Treasury, told a Lords committee that the full spending review, scheduled for the end of this year, is "unlikely" to be completed until 2020.

And a few days later another HSJ exclusive flagged up evidence that the "extra" money the government claimed to have allocated for the first year of the Long term Plan was being "part funded by a fresh raid on cash intended for capital investment in the service's buildings and facilities".

Another £221m towards the cash increase for 2019/20 was to be taken from another "capital to revenue transfer", along with another £250m previously decided in the 2015 spending review.

The HSJ quotes Sir Robert Naylor, whose controversial plan to generate capital investment in the NHS centred on a rapid sell off of "surplus" land and assets, now insisting that "We simply have to stop doing this because we've been starving the NHS of capital funding for decades."

Backlog

The Health Foundation has warned of the consequences, pointing to growing backlogs in maintenance.

The recent scandalous state of operating theatres in Oxford University Hospitals Trust's once prestigious John Radcliffe Hospital underlines the scale and impact of this neglect. The CQC has taken urgent enforcement action for the Trust's "failure to provide safe care and treatment," after finding that among other failures:

"The environment was not always suitable for services provided. Areas in some of the theatres and wards were damaged and in need of repair and posed potential risks to patient and staff safety.

"Staff in the main theatre department had become disheartened that the refurbishment had not happened and had accepted the environment they worked in was substandard. Risks were not adequately reflected on the risk registers."

The HSJ quotes Joshua Kraindler, economics analyst at the Health Foundation, warning that:

"the capital budget is, in real terms, the same as it was in 2010-11 and as a result, capital investment per NHS worker continues to fall. The funding environment is also leading some trusts to abandon long-term transformation projects due to the uncertainty of capital funding.

"At the same time, there is a rising maintenance backlog of £6bn, which is now larger than the annual capital budget and half of which is rated as high and significant risk."

If the current cash limits continue, some key parts of the NHS could literally break down and fall apart.

Early mental health interventions for young people don't go far enough

Hannah Flynn

The Government's plans to train teachers to spot the signs of mental illness in their pupils are "little more than a sticking plaster", says the National Educational Union.

Any genuine strategy to tackle mental health problems in young people should include efforts to reduce poverty and inequality and reverse NHS and school budget cuts, suggested Dr Mary Bousted, Joint General Secretary of the NEU.

Responding to Theresa May's announcement that the government will improve mental health training opportunities for teachers she said:

"Schools need strong pastoral systems, but teachers cannot cover for the cuts to mental health specialists. Recognising the early signs is important but timely routes to appropriate professional treatment is essential.

At the moment referrals lead to long waiting times – children and young people should not have to threaten or attempt suicide before accessing CAMHS".

Social workers and healthcare professionals are also set to be given more opportunities to access better mental health training as part of new policy to improve early intervention and prevention announced by the outgoing Prime Minister. NHS staff will have access to suicide prevention training.

This latest policy announcement echoes that of Jeremy Hunt's promise while he was heath secretary in 2017 to put a mental health lead in all schools by 2025.

Yet, chronic cuts to mental health services, alongside the impact of austerity policies on schools, families and local authorities since 2010 have resulted in a mental health care crisis within the NHS which successive health secretaries have repeatedly noted, but failed to meaningfully tackle.

A young people's crisis

Though the well documented crisis in mental health care affects people of all ages, mental health services for young people in particular have failed to keep up with demand.

This is in part due to an increase in demand in recent decades as admissions to hospital for self-harm have almost doubled since 1997, and self-reported mental health conditions among young people have increased six-fold in England since 1995.

While health care professionals must be at the forefront of treatment, teachers have long felt under-resourced in this area. A recent survey of teachers by charity YoungMinds highlighted 84 per cent of secondary school teachers have taught a pupil they believe self-harms, and 77 per cent of teachers did not feel they had sufficient training on children and young people's mental health.

Nearly half of pupils do turn to teachers for help when struggling with their mental health, figures from NHS Digital in 2018 reveal.

The NEU had been calling on the Government to put children's wellbeing at the centre of education policy for some time, Dr Bousted continued, but "the 'exam factory' culture of testing, driven from Whitehall, is one significant cause of anxiety and low self-esteem among young people," she explained.

Staffing slashed

Yet, while demand for mental health services is high and rising, cuts and austerity have meant that there are even fewer services than ever before for children and young adults to access.

Over 20,000 roles were unfilled in the mental health sector in September 2018, with up to 2,000 staff leaving a month, figures from the Department of Health and Social Care showed. This is despite Hunt's promise in 2017 to deliver 19,000 more mental health staff by 2021.

Nurse numbers have been particularly hard hit, with the scrapping of the bursary, uncertainty over Brexit and increasingly challenging working conditions all playing a role in the current 14.3 per cent vacancy rate for mental health nursing roles across England.

This represents a 13 per cent reduction in the total number of mental health nurses across all settings since 2010. A 19 per cent reduction in the total number of school nurses in England as well, doesn't help.

Catherine Gamble, Royal College of Nursing Professional Lead for Mental Health Nursing, points out that teachers already identify and support pupils with mental health issues, but notes: "It is vital, however, that there is sustained investment in mental health nursing to ensure those in need have access to the full range of treatments once mental health issues are identified".

This week the College said an additional £1 billion funding for nurses education was required at a minimum, if the Government was to recruit enough nurses to realise its NHS Long Term Plan.

Reduction in capacity

Even if there were enough staff to deal with the number of young people who need mental health services, it is unlikely the system has enough capacity to take them. The number of beds for mental health patients in England fell 30 per cent since 2009.

An overhaul of children's mental health services announced by Hunt in 2017 promised to slash waiting times for CAHMs to just four weeks from referral. Yet, an HSJ investigation last year showed hundreds of children were waiting more than a year, and over half of children referred to CAHMs were forced to wait 18 weeks.

What young people need

Early intervention for mental health is important, but similar to all other areas of health, it is useless if it is not the first step towards appropriate treatment.

Nick Harrop, Campaigns Manager at YoungMinds who have been campaigning for better early intervention for young people said: "We know from the young people we work with how hard it can be to access mental health support, and there is still a long way to go before help is available to every young person who reaches out.

"With rising demand, prevention and early intervention should be genuine priorities, and we need to see greater investment in community support beyond the NHS, so that young people can get the help they need when problems first emerge."

In numbers

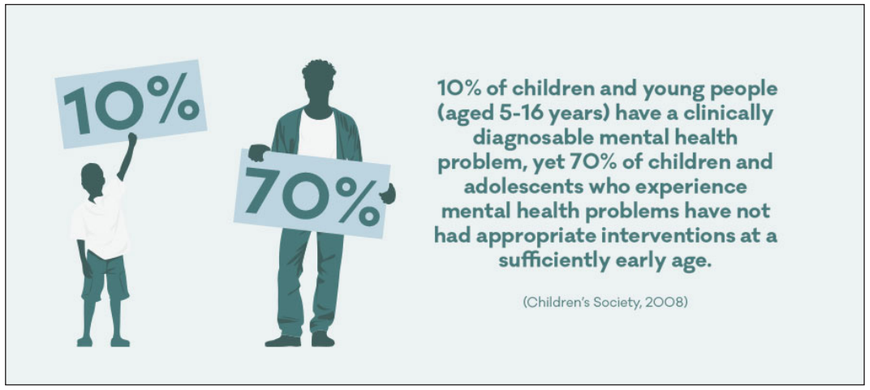
84%
of secondary school teachers have taught a student who they believe self-harms in the last year

77%
of secondary school teachers do not believe they have had sufficient training on children and young people's mental health

35%
do not feel confident knowing how to support young people with mental health issues.

37%
do not feel confident knowing how and when to refer young people to Child and Adolescent Mental Health Services.

Figures from a survey carried out by charity YoungMinds of 3,257 secondary school teachers in August and September 2018.



Keep Our NHS Public and Health Campaigns Together are holding a mental health summit in September.

Move to privatise cytology screening for London patients

Paul Evans

The result of an open tender competition to provide Laboratory services to the NHS will see one of the nine lots awarded this week likely to go to a private company.

Health services laboratories LLP has been confirmed as the preferred bidder and commissioners are expected to finalise the arrangements with the company.

The company is a for-profit partnership between The Doctors Laboratory - owned by Sonic Healthcare Ltd, an Australian clinical diagnostics organisation and two London NHS trusts – ULC and the Royal Free

Unions have already highlighted the threat to jobs as many of the existing units will close.

The tender was part of plan to centralise Cytology services and reduce the existing 46 laboratories to only nine. However, the process has already caused a mass exodus of biomedical scientists from the centres that were marked for closure.

The tender coincided with a wave of extra demand for screening tests in response to a Public Health England advertising campaign. Consequently, a huge backlog of samples built up with existing units understaffed and unable to cope with the extra demand

Delays of several months has caused unnecessary anxiety and a risk to health and has led the chair of the British Association for Cytopathology Alison Cropper to say that the cervical cancer screening service is 'in meltdown'.

Health secretary Matt Hancock has ignored calls from unite and the union who represent many of the staff affected to abandon the procurement.

Unite national officer for health Colenzo Jarrett-Thorpe said:

"Losing hundreds of skilled, highly qualified professionals from the NHS, thus eroding the science and technical skills base in the NHS, is to be deplored.

"The impact on thousands of women, who rely on cytology screeners to analyse cervical smear tests, is a huge concern."

It comes at a time when NHS England leaders are already under pressure to stand by their commitment to abandon the enforced tendering of NHS services, which they made back in January.

In a parallel tendering exercise, world renowned NHS cancer screening services in Oxford are being handed over to private firm Inhealth, despite an all-party appeal to ministers. However, a public campaign supported by MPs, councillors and local doctors is continuing to raise questions about the logic of the decision and highlight threats to patient care and the wider service.

The tender was part of plan to centralise Cytology services and reduce the existing 46 laboratories to only nine

Solutions to NHS staffing crisis delayed for Tory leadership campaign

Paul Evans

The NHS has been waiting for a workforce plan to layout the solution to its serious crisis in staffing. Interim plans have finally been published, but news that the government spending review is "unlikely" to take place this year will put a brake on further progress.

When NHS England published its 10-year plan for the NHS back in January 2019 plans for extra staff were missing - but promised later. It dented the credibility of the announcement and the absence of a work force plan was put down to a lack of agreement about funding.

An update from Treasury secretary Liz Truss to a Parliamentary committee has confirmed that the comprehensive spending review will likely be postponed because of the distraction of the Tory leadership campaign, which will come as a blow to NHS leaders as it was widely expected that this was the opportunity to resolve the funding issue.

It comes in week when the Health Foundation have hammered home the message that current funding arrangements will not be nearly enough to carry out NHS plans. They calculate that a further £8 billion needs to be spent over the next five years.

This is on top of the £20.5 billion, announced last year that did not factor in the cost of training and recruiting new staff.

The interim workforce document published by NHS Improvement sets out priorities and puts some targets in place, to start to address the giant 100,000 short fall in NHS staff, but reaction to the plan has been mixed. NHS leaders question how much can be achieved without settling the funding issue.

"A good plan is a good start, but for this to be more than a piece of paper, it needs to be backed up with money and people," said Nigel Edwards, chief executive of the Nuffield Trust.

Shadow health secretary Jonathan Ashworth called the interim plan "thin gruel ducking the big challenges of how to solve an escalating staffing crisis because Tory ministers have refused to back up the plan with the cash that is so desperately needed."

The new Tory party leader is expected to be announced at the end of July just before MPs head off for the summer recess. Brexit will be the priority for the new PM, with a tight timetable.

Throw in the growing possibility that Parliamentary gridlock could lead to a general election later in the year and the NHS might be in for a long wait for the extra funding it needs.

What do the interim plans say?

The delayed Interim People Plan, authored by NHS Improvement, opens with some straightforward admissions.

"The culture of the NHS is being negatively impacted by the fact that our people are overstretched – this is evident from the 2018 NHS Staff Survey where more people have reported bullying, harassment and abuse in their workplace in the last 12 months"

The plan sets a target to raise nursing numbers by 40,000 by 2024… However the size of target has already been questioned by research that estimates the number of nurses needed will be nearer 70,000 by 2024

The report points the finger at NHS management, identifying that "workforce planning has been disconnected from service and financial planning." NHS boards are often distracted by operational and financial issues.

The authors remind us that another period of big change in the NHS has started, "We need different people in different professions working in different ways" and they echo the themes set out in the long-term plan, around new multi-disciplinary teams working increasingly outside of hospitals.

The overall challenge is complex; new staff must be recruited, ex workers enticed back and training quickly increased, but the report also acknowledges that factors like pay and the conditions in which staff work, will all need to be tackled.

But the report has been slow in coming out and admits that it can't publish "detailed, costed action plans" until after the comprehensive spending review.

It promises a stepped approach "to take immediate action in 2019/20 while we develop a full five-year plan"

For an NHS workforce that has endured truly testing times and has waited a long time for support from policy makers, this will sound like warm words, when most are desperate to see action.

Boosting staff numbers?

The report admits that "urgent" and "accelerated action" is required to fill nursing vacancies in primary, community and mental health sectors.

The plan sets a target to raise nursing numbers by 40,000 by 2024, using four approaches

- international recruitment by appointing lead agencies to co-ordinate the process
- ensuring more nurses enter training
- improving retention rates by placing a greater emphasis on career developing
- encouraging nurses back into the NHS with the promise of flexible working opportunities

However the size of target has already been questioned by research that estimates the number of nurses needed will be nearer 70,000 by 2024.

There are also no plans to reverse George Osborne's disastrous decision to stop paying nursing students' tuition fees and maintenance grants, which has led to a huge drop in those applying to be nurses – 31% fewer between 2016 and 2018, at precisely the time when the profession needed to boost its intake.

Workers from abroad?

Throughout its history the NHS has relied on foreign health staff. One in eight of current NHS employees are foreign nationals.

The health secretary Matt Hancock has himself called for another Windrush generation, but the suggestion runs against the strong desire of Tory Party supporters to see immigration fall.

The Observer reported that plans to announce a 5000 a year target of nurses from abroad were recently dropped. The proposal would be hampered by immigration rules that could barr more than 40% nurses as they would need to earn at least £30,000 a year.

Without staff, we have no NHS

"Even if you take all the actions that we could identify … the nursing gap is not going to shrink at all in the next five years without international recruitment."

Many rightly question the morality of a recruitment policy that could drain talent from countries that badly need it for their own development. However, Mark Dayan policy analyst at the Nuffield Trust think tank believes that the options are very limited.

"Even if you take all the actions that we could identify in terms of boosting nurses in training, preventing them from leaving at the same rate, the nursing gap is not going to shrink at all in the next five years without international recruitment."

He says that 5000 extra nurses a year would half the recruitment gap by 2023/24 but still leave a lot to do, but without it pressing issues around patient safety and treatment delays will remain

Better conditions?

Few will fault the plan's ambition of "Making the NHS the best place to work", but the much of the detail, money and urgency that is needed is still missing.

A national return-to-practice scheme - set up in 2014 is being expanded and a new marketing partnership with Mumsnet aims to advertise job opportunities and entice nurses that have left the NHS to come back to work.

A major staff engagement exercise will be launched this summer, led by new chief people officer Prerana Issar, to "create an explicit offer to staff" that will address their major concerns.

However urgent action is needed, to stem the flow of staff leaving the NHS. The turnover of staff is high, one in 11 NHS staff quit every year, staff sickness is 2.3% higher than the wider economy.

Tough working conditions, poor career development and low pay have combined to drive thousands of trained staff away from their NHS careers.

UNISON head of health Sara Gorton said:

"Holding on to staff is probably the biggest challenge facing the NHS. All workers across the health service need to know they're valued and must be given the right training opportunities to use their skills and experience to move into more senior roles."

No time should be wasted before dealing with the evident bullying problem in some workplaces or in vanquishing the resistance to achieving ethnic diversity in NHS leadership positions.

Working under pressure

Routine gaps in the workforce make it difficult to fill medical and nursing rotas.

The everyday pressures of working long hours, sometimes beyond the limits of safety, are still widely felt amongst staff.

Over half work unpaid overtime very week. Stretching beyond safe limits sometimes results in tragic consequences. Trainee doctor Hadiza Bawa-Garba was found guilty of manslaughter by gross negligence in 2015 following the tragic death of a six-year-old boy from sepsis on a night when she was looking after six wards of patients without supervision.

The case sent a strong message to NHS staff that you can pay a big price for shouldering the burden of systemic staffing shortages.

A survey of nearly 8,000 doctors found that 95 per cent were fearful of making a medical error and more than half feared they would be blamed for problems arising from failures in the system, a factor in many doctors not completing their training.

It is hard to escape the fact that NHS relies on its staff but without taking proper care of them.

It can be as simple as being able to get a warm meal even if you're working a night shift, or having somewhere to rest, but fundamentally the capacity of the NHS must rise before staff will feel less overworked.

New leadership?

NHS Improvement has promised to change the leadership culture. No time should be wasted before dealing with the evident bullying problem in some workplaces or in vanquishing the resistance to achieving ethnic diversity in NHS leadership positions.

Almost 30 per cent of NHS staff said they had been bullied by patients or their families in the past year, with 25 per cent reporting abuse by other workers.

Matt Hancock said he is "horrified" that NHS staff surveys revealed 12 per of staff felt discriminated against, rising to 24 per cent for BME staff.

Dido Harding, chair of NHS Improvement, which is leading the work on the People Plan, said it was clear that there were "challenges" with staff.

She said "I want front-line NHS staff to know we have heard their concerns about the pressures they face and we are determined to address them.

"The NHS needs more staff. But that, on its own, is not enough. We need to change the way people work in the NHS and create a modern, caring and exciting workplace."

France: emergency staff fight for more beds, staff and salaries

John Lister

The French health care system is regularly touted by right wing commentators as superior in its performance to that in England – ignoring its considerably increased level of spending per head (€200 billion per year), superior availability of scanners and higher provision of beds.

But a major ongoing dispute in hospital emergency departments underlines the fact that inadequate staffing levels and funding can wreak havoc there too.

On June 10 emergency workers staged a national day of action, following on from strikes and protests which began in Paris back in March, and which have now reached to 95 emergency departments in hospitals across France. The strikes have been backed by French unions CGT, Sud and Force Ouvriere.

The strikers are complaining of funding cuts, a government reduction in the number of beds and a serious lack of medical staff leading to dire working conditions for emergency room staff.

The health ministry's figures show that from 2012 to 2016 emergency room visits in public hospitals (which make up the bulk of France's hospitals, and almost all of the emergency provision) increased by 12 percent, while the number of paramedics increased only by 5 percent.

The lack of resources has led to a mortality rate 9 percent higher than it would be in adequately resourced emergency departments, according to Christophe Prudhomme, spokesperson for the Association of Emergency Room Doctors, who warned last year that for patients in critical condition that number can reach as high as 30 percent.

François Braun, president of the ambulance workers'union said the French system of emergency care' has reached an unprecedented breaking point, as he issued the call for a five-minute walkout.

The stoppages have been restricted because it is illegal for emergency department staff to strike in France.

As a result their protests have taken various forms, with large numbers of staff taking sick leave to deal with 'burnout' after working excessively long shifts. In St Antoine hospital Paris, RFI reported 16 out of 19 staff members went off sick after having to work a marathon 18 hour stint the previous Saturday.

In Lariboisière hospital in Paris 65 percent of the emergency night team reportedly took sick leave shortly before their shifts were due to begin at 9pm.

But management have retaliated: hospital chiefs in Jura, eastern France sent gendarmes with requisition orders to the homes of healthcare workers, demanding they turn up for work.

Hospital chiefs in Jura, eastern France sent gendarmes with requisition orders to the homes of healthcare workers, demanding they turn up for work.

1.00am knock from police

According to an angry emergency doctor: "The police came to the door of a nurse at 1.00 am. She had already worked 72 hours that week."

Emergency staff say they are being forced to work long hours to compensate for staff shortages, and warn that this is putting patient care at risk. An investigation into the death of a 55-year-old patient a Paris hospital last December while awaiting treatment has found that the emergency department was overwhelmed with patients that day.

The emergency staff are demanding more beds, 10,000 more staff, and a €300 per month increase in pay. They have forced action from Health Minister Agnes Buzyn, herself a former hospital doctor, has refused to condone spurious taking of sick leave, but said that she "understands the impatience of emergency workers" as a result of the "unbearable everyday existence" they face.

She has announced five immediate measures to tackle the situation, including accelerating the renovation of dilapidated emergency department buildings, the creation of a bonus for paramedics who carry out duties normally carried out by a doctor, and the extension of another bonus which already exists for paramedics to cover more staff.

She has also asked MP Thomas Mesnier, who was previously an emergency doctor, and the President of the National Union of Emergency Services to come up with a plan to restructure the country's emergency services, with their proposals expected by November.

Privatisation, Secrecy – and Lies

RICHARD BOURNE argues that public bodies are not traders, and that most of their so-called business secrets should not be kept secret at all.

Campaigners against privatisation can rightly claim much credit for preventing the threats posed by the Health and Social Care Act ever being implemented. NHS England rhetoric around future NHS policy is now about removing the market and returning to policies of collaboration; no more compulsory tendering.

But some still don't hear the message. Campaigners must continue the struggle.

Thanks to vigilance and campaigning the vast majority of NHS services do not go through any kind of tendering or procurement. Only a small percentage (perhaps 8%) of core NHS services are placed with for profit organisations by commissioners and the increasing trend since 2006 has levelled off.

However some CCGs and commissioners of specialist services are still making plans to tender for 10 year contracts for NHS funded services.

And these figures do not include the outsourcing of support services by hospital trusts. Once again some NHS Trusts are trying to outsource services to make tax gains.

Those who campaign against outsourcing and privatisation often face a serious obstacle: we cannot get the information we need. Secrecy prevails, so we cannot show that what is said in public is simply not what was agreed in private.

The key to understanding what is planned will be in the Business Case.

Every NHS body contemplating a significant procurement must produce a business case, and that is the mechanism through which accountability is established. And the last thing most NHS bodies want is to be accountable.

Instead public bodies fully funded by us claim that in fact they are commercial bodies competing in a market and forced to protect their position by keeping everything secret, invoking "commercial confidentiality". They refuse to provide information about what they are planning to do, and more importantly why they are planning to do it.

Typically, a campaigner or staff representative picks up that there is a plan to outsource a service or to "reconfigure" and that there will have to be a procurement and competition.

So, you ask to see the papers relating to the decision, and the Business Case used to justify it. But the request is refused, so you resort to using the Freedom of Information Act.

But that takes a lot of time.

I have two cases in mind where the decision to refuse information was fought through every step of the process … and 18 months later in each case full disclosure was ordered. There was no apology; just grudging compliance.

It was eventually obvious that the reason for withholding information was actually because the business case was so poor it would have embarrassed the organisation.

There have been attempts to persuade NHS leadership (nobody knows which organisation does what any more!) to send out very clear messages – that:

- tendering and competition is to be avoided
- and if it is used then everything about the process must be open and transparent.

Part of the problem is of course the lack of funding. In many cases bringing services back into the NHS and avoiding outsourcing requires investment in the NHS to rebuild lost capacity. Sometimes the NHS cannot provide a service, so someone else comes in – but the answer is to build NHS capacity as an investment, not waste money on short term get arounds.

So for every procurement there should be a clear statement about what it would require to build NHS capacity as an option. Then some test of overall social value ought to apply, not just financial.

But this is useless unless we can all see the case being made and put our arguments forward.

Which comes back to commercial confidentiality – and lying.

Public bodies fully funded by us claim that in fact they are commercial bodies competing in a market and forced to protect their position by keeping everything secret

Information can be withheld if disclosure would or would be likely to prejudice commercial interests. Well, for a start, public authorities are rarely trading entities and their interests are rarely commercial.

But there is a limitation placed on this anyway. That requires that "the chance of prejudice being suffered should be more than a hypothetical or remote possibility; there must be real and significant risk".

This justification has to be spelt out objectively with facts if a request for information is declined. That is incredibly unlikely ever to be met.

In respect of the vital Business Case disclosure there is strong guidance anyway from 2008 which sets out what can and should be disclosed during a procurement. This makes clear that all vision planning and strategy documentation including the Business Case can be disclosed once the bid documentation has been issued. **Basically, the public has the right to know as much as the bidders!!!**

So information should be available before any decision to award a contract is made. The only things that are genuinely confidential are matters flagged as such by bidders, such as trade secrets – and even then a public interest test can overrule that desire for secrecy. Public bodies are not traders!

Yet while a few do publish the case in full on their web site – good for them – too many CCGs and Trusts routinely refuse to provide Business Cases even after contracts have been awarded.

It is time we stepped up the campaign to make sure NHS leadership who have so far been complicit in this secrect and decption make sure CCGs and Trusts act openly and transparently and stop hiding behind bogus confidentiality.

THE lowdown

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

The Lowdown launched earlier in February 2019 with our first pilot issue and a searchable website.

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – something that that isn't currently available to NHS supporters.

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

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

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

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

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

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

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

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

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

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

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

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

Why is it needed?

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

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

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

In our first year we will:

- establish a 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 organisations who have already given or promised generous donations to enable us to start the project going.

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

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

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

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

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

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

- **If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at contactus@lowdownnhs.info**