THE lowdown

Health news, analysis and campaigns.
NUMBER 20, March 18 2020

Informing, alerting and empowering NHS staff and campaigners

Petition calls for action to ensure safety of staff and patients

A group of NHS doctors and nurses are calling for support as the country faces a dangerous pandemic, warning that while we are relying on the NHS and social care more than ever, they have both been dangerously weakened by years of cuts.

They have launched a petition that brings together a number of the key issues that have been raised by trade unions and professional bodies, and calls for government action.

Their statement warns that:

"The shortfall in staff, equipment and beds mean we're not in the position we should be - and this will needlessly cost lives.

"17,000 NHS beds have been cut since 2010 while private hospitals get 30% of their income from NHS patients on waiting lists.

"Tens of thousands of staff are outsourced from the NHS to private companies. Many have zero-hour contracts lacking the security of paid sick leave and face very difficult decisions to self-isolate and lose pay.

"Undocumented migrants and others are told they are not eligible for free NHS care. Many fear approaching the NHS worried about unpayable bills or being reported to the Home Office.

"As NHS staff, we know the pressures on staff even before Coronavirus hit and we know the fears of outsourced workers and undocumented patients facing economic hardship.

"We must value our staff and ensure their security and we must ensure our patients trust the NHS to treat them without reservation.

"This pandemic shows that a thriving publicly owned and run NHS and social care sector are essential to ensure that all citizens have equal access to the best care. Indeed, a thriving state is essential for a thriving society.

"That's why we're calling on the Government to urgently take the following measures to protect NHS workers and the general public:

- Covid-19 testing and personal protective equipment (PPE) must be available for all NHS and social care staff now
- Those relying on social care (or 'Direct Payments') must be given immediate support if carers go sick
- NHS support staff (including those outsourced) must receive at least living wage, paid sick leave for illness or self-isolation and an increase in statutory sick pay
- Bring private health resources into public service without compensation to fight COVID-19 and aid NHS response
- Make all information that the Government is basing its strategy on wholly available for public scrutiny
- An immediate end to legislation enforcing eligibility checks and charging in the NHS, including those related to residency status or national origin, allowing all patients to use the NHS without fear

We must value our staff and ensure their security and we must ensure our patients trust the NHS to treat them without reservation

Please sign the petition to strengthen the NHS response to coronavirus.

Dr Sonia Adesera; Dr Tom Gardiner; Dr Helen Salisbury; Dr Mona Kamal; Mark Boothroyd A&E Staff Nurse; Gay Lee Palliative Care Nurse; Iain Wilson Clinical Nurse Specialist; Dr John Puntis; Dr Tony O'Sullivan; Alia Butts CAMHS Specialist Practitioner and Psychotherapist; Dr Brian Fisher (SHA); Cllr Dr Hosnieh Djafari-Marbini; Dr Coral Jones, GP; Dr Yannis Gourtsoyannis Infectious Diseases; Dr Rita Issa, Academic Clinical Fellow in General Practice; Dr Aislinn Macklin-Doherty, Oncologist; Dr Louise Irvine

IN THIS ISSUE

What did China do to beat back the virus?

The last batch of medical workers pose for a photo after walking out of the temporary hospital of Jianghan, in Wuhan, capital of central China's Hubei Province, March 9.

Paul Evans

A report from the World Health Organisation and China Joint Mission on Coronavirus Disease provides the first scientific assessment of China's aggressive approach towards controlling the spread of the virus.

A 25-strong team of scientists, including 12 scientists from around the world were given extensive access as the authorities fought to bring the epidemic under control.

Their report concluded that, "China has rolled out perhaps the most ambitious, agile, and aggressive disease containment effort in history."

The report's authors were in no doubt about the effectiveness of the strategy.

"China's bold approach to contain the rapid spread of this new respiratory pathogen has changed the course of a rapidly escalating and deadly epidemic," it says. "This decline in COVID-19 cases across China is real."

Speaking before World Health Organisation announced a pandemic Dr Bruce Aylward the academic leading the project suggested that other countries could contain the virus if they learned from China's approach.

Early intervention

Further research by a team at Beijing Normal University found that the Chinese cities that introduced control measures before their first case of COVID-19 subsequently had 37% fewer cases of the disease.

The study looked at the responses of the authorities in 296 Chinese cities. The most effective strategies included suspending intra-city public transport, closing entertainment venues and banning public gatherings.

The researchers concluded that by day 50 of the crisis (Feb 15) the national emergency response delayed the growth and limited the size of the COVID-19 epidemic preventing hundreds of thousands of cases across China.

UK changes strategy

In the last few days the British government has changed its tack on the virus after a mathematical model by Imperial College predicted that up to 250,000 people could die unless strict social distancing and home quarantine measures were taken.

The government has said all along the that more stringent steps were in its action plans, deploying them gradually, but a string of senior academics and politicians have publicly questioned the strategy, pointing to the success of early intervention in China and the extensive testing regime in South Korea, which has offered an alternative approach to lockdown.

South Korea has tested more than 270,000 people - 5200 tests per million inhabitants, more than any other country except tiny Bahrain, according to the Worldometer website

Chinese cities that introduced control measures before their first case of COVID-19 had 37% fewer cases of the disease

What steps has China taken?

On 10 January 2020, the first death and 41 clinically confirmed infections caused by the coronavirus were reported.

By 22 January 2020, the virus had spread across China, with 571 confirmed cases and 17 deaths reported.

A day later Chinese leaders announced the decision to lock down, Wahun and nearby cities, banning all travel without permission, quarantining 50 million people.

By 3 February 2020, the Chinese government shut down all non-essential companies, including manufacturing plants, in Hubei Province.

The WHO report concluded that this "effectively prevented further exploitation of infected individuals to the rest of the country". In other parts of China people voluntarily quarantined themselves.

Chinese adopted a three-phase strategy first preventing the spread of cases from the source and blocking transmission. Early media reports from Wuhan showed a situation which appeared out of control.

Medical facilities were over run and struggling healthcare workers were themselves succumbing to the disease. Phase 2 quickly introduced more extreme restrictions and social distancing. And these were only lifted at the start of the third phase as the number of new cases consistently fell.

Public health effort

The scale of the Chinese public health effort was impressive. In Wuhan alone more than 1800 teams of epidemiologists, each with 5 people collectively traced tens of thousands of contacts each day, quickly putting people into isolation.

Anyone who went outside had to wear a mask. Mass gatherings were banned and shops and schools were closed.

Apps were used to allow the state to monitor the movement of infected people, a step which other countries could not, or would not take.

Zhejiang Province made extensive preparations in advance of their first reported case. But by 2 February 2020 they had implemented a seven-day lockdown

in which only one person per household was allowed to exit once each two days.

A system of health QR codes was used by everyone in Hangzhou to track and stop the progress of the virus. Each individual was responsible for recording their temperature and updating their online profile.

After filling out the questionnaire, users receive a colour-based QR-code, on their mobile phones indicating their health status. Green code allowed free movement, yellow required seven day quarantine whereas red a 14 day self-quarantine.

Of course, overall the measures were strong, but the WHO team also found that the Chinese varied their approaches, decision that they could make based on huge pool of new medical information that they collected.

Invaluable data

The data compiled by Chinese scientists has been invaluable in informing the other countries, providing a basic profile of the virus and how it impacts upon the population. They found that;

- 80% of infected people had mild to moderate disease,
- 13.8% had severe symptoms,
- 6.1% had life-threatening episodes of respiratory failure, septic shock, or organ failure.
- The case fatality rate was highest for people over age 80 (21.9%), and people who had heart disease, diabetes, or hypertension.
- Fever and dry cough were the most common symptoms.
- Surprisingly, only 4.8% of infected people had runny noses.
- Children made up a mere 2.4% of the cases, and almost none was severely ill.
- For the mild and moderate cases, it took 2 weeks on average to recover.

Community cohesion

Of course, the measures were applied strongly by the Chinese authorities and in ways which other governments could not to emulate. Despite the sanctions the WHO report commented on the level of community spirit and cooperation.

"Everywhere you went, anyone you spoke to, there was a sense of responsibility and collective action, and there's war footing to get things done," Dr Aylward says

Now that restrictions are being lifted attention is shifting to the mental health damage done as a result of the confinement and the anxiety about loss of income and business collapse.

The Head of Psychology at Tsinghua University, Dr Peng Kaiping, has told ITV news that his institution has already had calls from people experiencing the severe depression and distress symptoms usually associated with PTSD.

As of 18 March new cases in China continue to fall compared to the accelerating crisis across Europe.

Too few midwives impacts on safety

RCM Northern Irish members striking on pay and staffing levels

The Royal College of Midwives' latest survey of the state of midwifery departments paints a difficult picture of staff shortages, a lack of funding and low morale.

Midwife vacancies have doubled in a year and a lack of staff means that midwives are being redeployed away from community work to cover the essential areas - the labour wards and delivery suites. This means that key areas of work are now being cut back and the choice for pregnant women is reducing.

Short of staff

The RCM survey of Directors and Heads of Midwifery, part of evidence presented by the RCM to the NHS Pay Review Body, found that over half (54%) report not having enough funding for adequate staffing levels and eight out of ten (80%) have midwife vacancies and the number has almost doubled from 611 in 2018 to 1056 in 2019.

The survey also found that staff morale was a major issue, with over two-thirds (72%) saying morale was just ok or poor, up from half (50%) in 2018.

Commenting on the findings of the RCM survey, Gill Walton, Chief Executive and General Secretary, said:

"Despite positive government commitments to increase midwife numbers our maternity services are facing increasing demand and insufficient staffing and resources.

"This impacts on the quality of care women are receiving and most importantly it is affecting the safety of our maternity services. We need to see the pace of midwife increases stepped-up and more investment put into our maternity services."

Reducing services

Maternity units in 2019 had to reduce services more often than in 2018, with almost a fifth (17%) saying they had to reduce services in the past year compared with 7% in 2018, and seven out of ten (74%) reporting that they had to redeploy staff at least once a week to cover essential services compared to 62% in 2018.

A few days after this survey came out, a report from the Care Quality Commission (CQC) on maternity units found that maternity units continue to show similar failures to those identified by the inquiry into the baby deaths in Morecambe Bay five years ago.

The regulator highlighted a lack of quality training for maternity staff and warned some obstetric staff who saw low numbers of births were not maintaining their skills and posing serious risk to mothers.

At the end of 2019, The Independent reported on the deaths of dozens of babies in the Shrewsbury and Telford Hospital Trust - a potentially even larger scandal than Morecambe Bay. And in Kent, The Lowdown reported in late February on the inquest into the death of baby Harry Richford, who died at Queen Elizabeth the Queen Mother Hospital in Margate back in 2017, noting the failures in maternity being so often linked with low levels of investment, staff shortages, poor morale, and bullying.

■ The continued and growing problem with workforce capacity in maternity services, highlights the urgency for a full and detailed workforce plan. The Royal College of Nursing (RCN) called for the Government's budget to tackle the workforce problems after a National Audit Office report found the NHS 'does not have the nurses it needs'.

An interim NHS People Plan to address the workforce crisis was released in June 2019, with the full plan promised at the end of 2019 .

Months on and there is still no plan.

The Chancellor's first budget in early March, focused mainly on cash for the NHS to deal with coronavirus rather than addressing workforce issues.

The RCN noted the government's reiteration of a commitment to increase nurse numbers, but also that there was a lack of any detailed plan on how the 50,000 promised will be educated, recruited and current nurses persuaded to stay.

Homeless people 60 times more likely to visit A&E

Sylvia Davidson

The number of rough sleepers on the streets of England and Wales has risen over 140% since 2010 and they are being badly let down by health and care services. In 2018, 726 rough sleepers died, up 22% on the previous year, with the average age of death at 45 for males and 43 for females, that is three decades younger than the general population.

As part of the government's Rough Sleeping Strategy announced in 2018, The King's Fund was commissioned to determine why healthcare systems are failing rough sleepers so badly and report on good practice.

The report, released in early March, noted that ultimately the poor health and reduced life expectancy of rough sleepers can not be fixed by the NHS alone, tackling rough sleeping involves improving people's health, social wellbeing and housing situation as well as supporting them to find long-term solutions.

However, the report also highlights good practice that can help improve access to the NHS for rough sleepers who currently face many barriers.

Barriers

Barriers to access include the attitude of some staff, complex administration processes and previous negative experiences.

Often the health problems of rough sleepers are not picked up until the issue is acute and rough sleepers are far more likely to visit A&E. A study from the University of Birmingham in 2019 found homeless people in England are 60 times more likely to visit A&E than the general population.

This propensity to visit A&E is not surprising - it is relatively anonymous and the first question is not "what's your address?"

The complexity of the NHS is baffling to many who don't have the additional difficulties of those sleeping on the streets. Continuity of care is made extremely difficult due to the need for an address for letters about appointments.

Richard Vize writing in The Guardian about this subject, noted that while "the NHS and local government talk about "hard to reach groups", their champions in the public sector argue it is the services themselves that are hard to reach."

The King's Fund's report identified five common principles of delivering effective health care to people sleeping rough, which can be summarised as follows:

- "Find and engage people sleeping rough";
- "Build and support the workforce to go above and beyond" to encourage integrated and flexible working practices;
- "Prioritise relationships," because efforts to connect individuals quickly across different services spanning housing, social care and health work best when staff know each other personally.
- "Tailor the response," because a "generic 'off-the shelf' approach to improving health and care outcomes for people sleeping rough will not work"; and
- "Use the power of commissioning" with commissioners working together across the NHS and local authorities to deliver integrated services that address the complexity of need among the population who sleep rough.

These approaches are all commonsense, however in the real world NHS services have to work with a host of other services for the homeless provided by local councils and since 2010 these services have been cut to the bone.

Local authorities are spending £1 billion less a year on homeless services compared to ten years ago, while homeless-ness in England has risen dramatically.

Spending cuts

Council spending on supporting single homeless people in England fell 53% from 2008-9 and 2017-18. Local authorities are spending £1 billion less a year on homeless services compared to ten years ago. During the same period, homelessness in England has risen dramatically.

This is entirely down to government policy: the number of rough sleepers was falling when in 2009 the ring-fence that protected the funding for the Supporting People programme – a programme for people struggling to live independently to avoid and escape homelessness – was removed and the levels of housing-related support funding was reduced.

The result has been a massive increase in homelessness and rough sleepers and a decrease in places for them to seek shelter and help.

In December 2019, the charity St Mungo's reported that there were 8,755 fewer places in accommodation services for people compared with nine years ago.

The government's answer to the escalating problem is the Rough Sleeping Strategy announced in 2018, part of which was the report by the King's Fund.

Whilst this has provided some additional funding for homelessness services, it falls short of replacing the lost £1 billion per year funding. The strategy commits £1.2 billion over five years, with £100 million earmarked to halve rough sleeping by 2022 and end it by 2027.

As coronavirus highlights bed shortages,
SW London plan to halve bed numbers

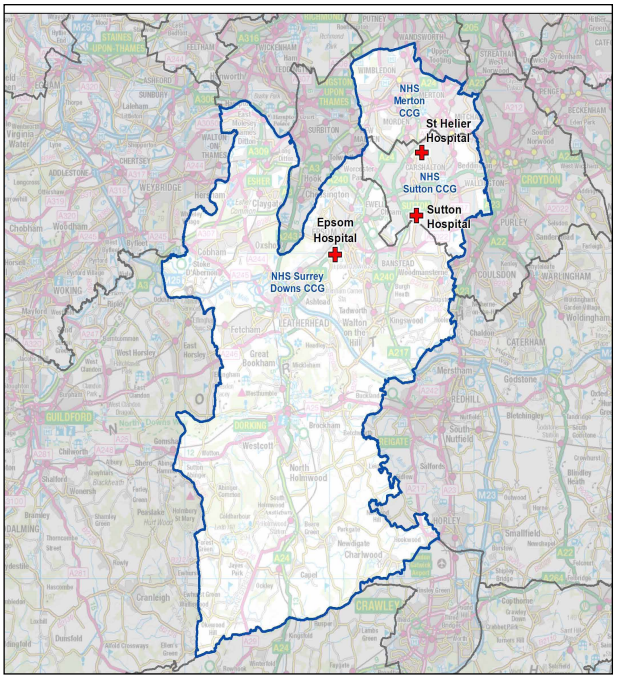
John Lister

One of the six new hospitals announced by the government last year could result in a loss of half the front line beds at the Epsom & St Helier University Hospitals NHS Trust, according to a detailed and damning 30-page response from the local UNISON branch.

Such a massive cutback – at a time when the coronavirus is focusing public attention on the inadequate numbers of general and acute beds available in England's NHS after ten years of cutbacks – would fly in the face of the latest Planning Guidance from NHS England, which calls for front-line bed numbers to be maintained at least at the level of winter provision 2019-20: in Epsom & St Helier this is reported to range from 740-790 beds.

But now Merton, Sutton and Surrey Downs CCGs are consulting on four "options" for reconfiguring hospital services serving a population of 720,000 in South West London and Surrey, with the favoured "option 4" proposing a new £500m, 520 bed "specialist emergency care hospital" to be built on the old Sutton Hospital site .

But UNISON warns that after day care beds, maternity beds and 24 private beds are deducted from the total of 520 beds in the new Sutton hospital, the remaining numbers of "core" beds open 24/7 to treat emergency and waiting list patients at the would be reduced to just 386.



The catchment area includes 720,000 people in SW London and Surrey

From two sites … to THREE

The favoured option would also move from the existing two hospital sites (Epsom and St Helier in Carshalton) to THREE. Both existing hospitals would be downgraded – each losing its A&E – and downsized, with bed numbers slashed from the present 454 at Epsom and 594 at St Helier to just 273 at Epsom and 183 at St Helier, with surplus land sold off in a bonanza for developers.

Epsom and St Helier hospitals would be left providing only an urgent treatment centre, "district hospital" and community hospital beds, day surgery and outpatients.

ALL of the Trust's reduced number of consultants, and all specialist surgery and treatment would be located at the new hospital in Sutton, leaving the district hospital beds staffed by less qualified "interface physicians" and a reduced proportion of registered nurses.

UNISON also warns of the probability that the location of the new hospital right next to the Royal Marsden Hospital and a new London Cancer Hub would result in staff, beds and theatre time being diverted to surgical work on Royal Marsden's cancer patients (many of them private patients) – meaning a further loss of front line NHS beds for the 720,000 population who currently use Epsom and St Helier hospitals.

The 3-site system would also mean considerable numbers of patients would have to be transferred soon after surgery from the specialist beds in Sutton to complete their recovery in "step down" beds at Epsom or St Helier, while any district hospital patients developing complications would need to be transported by ambulance to Sutton.

Strain on ambulance services

UNISON is concerned that no proper reckoning seems to have been made of the impact this could have on ambulance services, and the need for additional vehicles and crew.

UNISON questions whether the proposals are the best – or indeed any kind of solution to the three problems which are cited as reasons why change is needed – shortage of staff, ageing buildings and financial pressures.

UNISON notes that other trusts in the area have similar staffing problems despite having centralised services on a single site, and that the plan ignores advice from the Royal College of Emergency Medicine that "Workforce shortages are a poor justification for service reconfiguration."

The claimed financial savings from the proposals centre on a reduction in numbers and skill levels of staff, putting the scale and quality of patient care at risk: and UNISON argues that the plan is a costly way of tackling the Trust's maintenance backlog of £96m.

The union notes that among the various flawed plans that have come and gone over the past 20 years or more, the one that attracted widespread support was the 2009 plan to rebuild a new hospital on the St Helier site and upgrade Epsom, and advocates a return to this:

"For far less than £500m an updated version of the 2009 plan to build a new St Helier Hospital and upgrade and expand Epsom could deliver better results and better accessibility, leaving additional resources to improve and expand community health, primary care and mental health services."


UNISON IN TOUCH

Bulletin of UNISON Epsom & St Helier Branch ● No. 27 Autumn 2009

INSIDE this issue

Concerns over Sutton Hospital – page 2

Cash in on your new discount card – back page

Swift staff response as ambulance goes up in flames – page 3

UNISON calls for early start on rebuilding Epsom and St Helier

Let's get the new building started!

The 2009 plan for new St Helier hospital was axed in Cameron government's austerity clampdown

The slow killing of the NHS by salami-slice

Oxfordshire Keep Our NHS Public report

The number of private companies that run parts of the NHS in Oxfordshire is growing. In each contract, a provider agrees to deliver, for a certain number of years, a particular service within a "performance framework".

Some of these contracts are with the local Clinical Commissioning Group, some with NHS England, some with NHS hospital trusts (Oxford University Hospitals, and mental and community health).

These contracts are by their nature rather inflexible. And, since they are held by private companies, they are not easy to change during the lifetime of the contract.

Contracts are awarded on the basis that they fulfil certain targets. But in the contracts with private companies that we have looked at, a number of targets were not met. We've also found that problems highlighted in patient testaments are not covered by the performance framework. So, complaints, in these cases, are ineffective.

Health services must be flexible - episodes and epidemics are not predictable. They need staff, wards, A&E, operating theatres that can work as professionally and compassionately as possible, where problems and hold-ups can be quickly addressed. This requires services run by professionals confident in their staff, their back-up, their buildings and equipment.

This report, based on performance during 2018-19 of some of the main private contractors, shows that contracts with the private sector hinder rather than help this to happen. For instance, the NHS main website awards one of them, HealthShare, just 1.5 stars out of 5. InHealth (which provides diagnostics) was only awarded 2 stars out of 5.

Where is the evidence on the local private sector in Oxfordshire?

I. Background

In Oxfordshire, the Clinical Commissioning Group has a number of contracts with private providers. These include:

- HealthShare (physiotherapy and all things musculo-skeletal)
- InHealth (endoscopy, colonoscopy, echocardiogram)
- Physiological Measurements Ltd (diagnostic services)
- Boehringer–Ingelheim (a pilot joint specialist community team for those with respiratory problems). The funding is joint. BI say they have no clinical input.
- Specsavers, Scrivens and The Outside Clinic (audiology services)
- Other smaller contracts and grants related to other areas outside of planned care.

This includes:

- provision of diagnostic services for autism,
- work with the third sector to deliver falls-prevention programmes,
- several services delivered by individual GP practices such as skin cancer monitoring and minor surgery,
- a company called Ingeus to deliver a diabetes prevention programme locally,
- and Oxon GP Federation provision of access hubs for primary care, Hospital at Home services, out of hours, and some specialist clinics.

The NHS main website awards one contractor, HealthShare, just 1.5 stars out of 5. InHealth (which provides diagnostics) was only awarded only 2 stars out of 5.

In addition to private companies commissioned by the CCG, there are some commissioned by NHS England. These include:

- Healthcare@Home (follow-on cancer care at home)
- Alliance Medical (diagnostics)

All this adds up to a very complex environment for GPs, hospital consultants, and the general public. There are likely to be problems in the following areas:

Access. Will the clinic be easy to find? Properly indicated? Pleasant to use? Not far from home?

Communication. Will the private provider send information back to the GP quickly? Will the GP be able to ask follow-up questions?

Getting changes to service. If the reports from patients are bad and the service is not good, how easy is it to get changes? What kind of complaints procedure or monitoring opportunities are there?

II. Problems with the contracts

The second area of difficulty is the contract. How is it monitored?

What are the criteria for measuring success of failure? What happens if things go wrong? Can a contract be ended?

III. How successful are these contracts in Oxfordshire?

We have two main sources of evidence: the performance monitoring framework and testimony from patients or their GP or consultant.

We have been able to obtain monitoring reports for only three of the providers. But they do contain some interesting information.

InHealth (endoscopy, colonoscopy, echocardiogram)

According to the targets in the contract:

Referrals within 6 weeks, agreed threshold 95%. Result: average 80.35%, lowest in one month 45%.

Referrals within 2 weeks for suspected heart failure, agreed threshold 95%. Result: average 92.7%; in 2 months only 50%.

Seen within 30 minutes of the time given for appointment, agreed threshold 90%. Result: 100%

Patients offered appointment within 5 days,

agreed threshold 98%. Result: 100%.

Urgent findings processed on day of scan, agreed threshold 100%. Result: 99%; in 2 months only 93%.

The agreed threshold, therefore, allows for a failure rate of around 5% routinely on most measures. This in itself is not acceptable to the public. The actual reported performance shows some frankly unacceptable deviations from even this agreed threshold.

If these services were in house, problems could be dealt with quickly. As it is, these private contractor problems interfere with the patient journey, causing holdups. They also interfere with NHS performance data and thus contribute to headline failure ratings for CCGs and NHS trusts.

Endoscopy, urgent cancer referral: performance indicators

"2 week wait" patients (referred urgently by their GP or clinician). Target: 98%, result: 67.6% (April 2018 to March 2019)

"1-day referral" ("booked within one day"): target: 98%, result: 43.9%

The indicator for how quickly people are booked in for cancer diagnosis in urgent referral cases is clearly crucial. It appears in InHealth's performance framework as "% 2-week wait patients booked within 5 days of referral".

From April 2018 to March 2019 the success rate was 67.6%. This cannot be seen as acceptable. Yet because this is a service in the private sector, the patient, the GP, and the consultant are powerless to act. They can complain, get the service investigated, and report to the CCG that the target of 98% has not been met this year - but that is all.

There is another slightly mysterious indicator in the framework for "non e-referrals". One could surmise that this was a route for the very urgent cases, where the GP rings up InHealth saying please fit this one in asap because the target - still 98% - is "booked within one day". But here the report contains the even more disturbing news - only 43.9% of referrals were actually booked within the one-day slot.

Healthshare

Healthshare, which took over all Oxfordshire's muscular-skeletal services a couple of years ago, has been subject to continuous scrutiny after a poor report reached Oxfordshire's Joint Health Overview and Scrutiny Committee last year.

From April 2018 to March 2019 the success rate was 67.6%. This cannot be seen as acceptable. Yet because this is a service in the private sector, the patient, the GP, and the consultant are powerless to act.

The performance framework HealthShare agreed with the CCG shows no target for length of time from referral to treatment. It simply said that patients should be offered "first or second choice of MATT (musculoskeletal assessment, triage, and treatment) within 10 working days". Within 10 working days of what?

The target HealthShare had agreed to, which may have helped win them the contract, was 95% and was apparently exceeded – 100%. In fact their indicator targets were mostly exceeded, except for the "patient discharge letter to GP within 3 working days": target 95%, actual 92%. Not bad.

However one patient, months after filing a complaint, finally received a letter from Healthshare suggesting the problem was not their end – they had completed paperwork correctly but:

"Unfortunately, onward referral has to be a two-part process as the patient administration system and the onward referral system are separate, however we are investigating the use of software that will allow the two systems to integrate."

In other words, one of the results of signing away one part of the NHS patient journey to a private provider is that the connections don't work (incompatible IT systems). And patients fall through the cracks.

■ **See the full report by Oxfordshire Keep Our NHS Public, which also includes fascinating first hand reports and case studies.**

URGENT APPEAL: we still need more support

A huge thank you to the individuals and union branches that have added their support to our appeal for financial support: but the cancellation of many labour movement events has made our campaign for resources to keep Lowdown much more difficult.

We hoped to fund the publication through donations from supporting organisations and individuals to avoid imposing a paywall that would exclude many who cannot afford to subscribe.

Having managed to raise enough money for our first year, and some more so far this year, the money is now running out and we urgently need more to keep going through the summer.

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

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

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

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

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

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

History of NHS Privatisation – Part 2

Community care – and the birth of the internal market

John Lister

Today's discussions on the crisis in social care – the heavily privatised provision of home care and care homes for older people and for people with serious and long-term mental health problems, learning difficulties and physical disability – seldom make any reference to the fact that many of people receiving these services used to be provided for by the NHS.

Thousands of long-stay specialist beds for older patients (geriatric beds) provided care for patients free at point of use: all of these have since closed, to be replaced by largely private sector provision of home care services and a mix of for-profit and non-profit private provision of nursing home care: this was the biggest area of privatisation in the NHS.

In 1987 the NHS had 127,616 acute hospital beds (handling emergency and elective care) and another 52,273 geriatric beds, giving a "general and acute" beds total of 180,889. 20 years later geriatric bed numbers had been cut by over 60% and acute beds by 20%, to give a total of 122,374. Since 2010 the category of "geriatric beds" has disappeared and the total of general and acute beds at the last count has fallen to 101,598 – a reduction of 44% in 32 years.

The Thatcher government, tearing up the "consensus" policies of much of the first 30 years of the NHS, began to shift the argument in 1981 with the publication of a White Paper Growing Older (DHSS 1981) and a consultative document Care in the Community (DHSS 1981), both of which centred on the drive to transfer patients and services out from hospital settings into "the community."

The consultative document suggested that funds for community-based services would depend upon the sale of surplus land and buildings. These discussions took place under a growing cloud of well-founded suspicion that the NHS was looking to community care as a smokescreen to cover its abdication from responsibility for a growing area of care for the frail elderly and people with chronic mental illness.

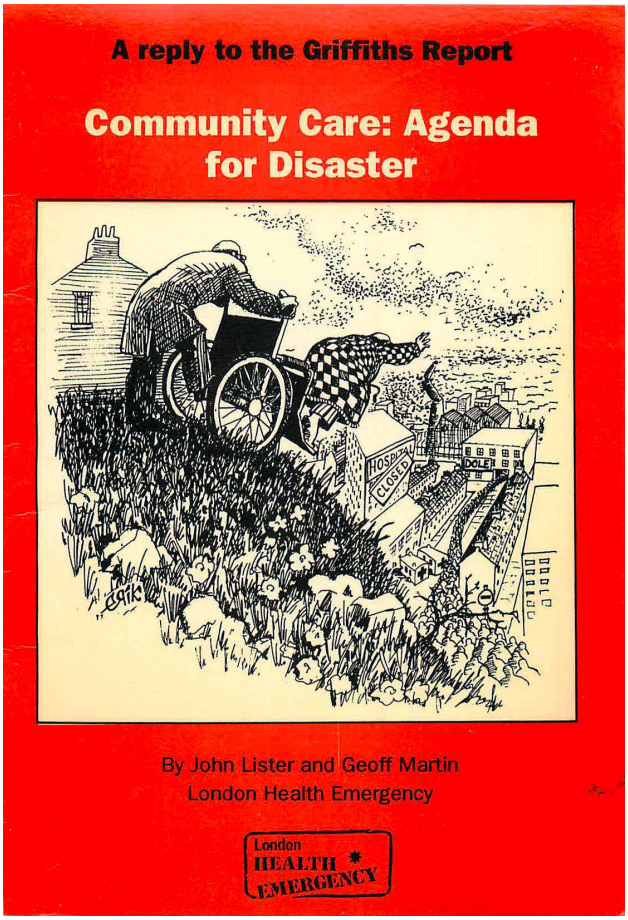
Guidelines ignored

The guidelines for provision of beds for the elderly drawn up by the DHSS in 1976 had been massively and systematically ignored by cash-strapped Regional and District health authorities. By 1984 a survey by Shadow Health minister Michael Meacher revealed that not one region in England was planning to meet the targets laid down for in-patients or day hospital places. Instead thousands of beds for the elderly had closed.

Despite a demographic "explosion" which was creating a sharp increase in numbers of elderly people in the vulnerable 75-plus age group, NHS plans across the country were looking to reduce bed numbers to an average of 25% below the 1976 guideline provision – with an even bigger (50%) shortfall in the provision of day hospital places.

While the closures of geriatric beds and the shortfall in care for the elderly grabbed headlines, behind the scenes

Private nursing and residential homes offered an attractive proposition; numbers of homes and places rocketed during the 1980s. Nursing home places increased from 18,000 in 1982 to 150,000 in 1994 while NHS provision was rapidly reduced



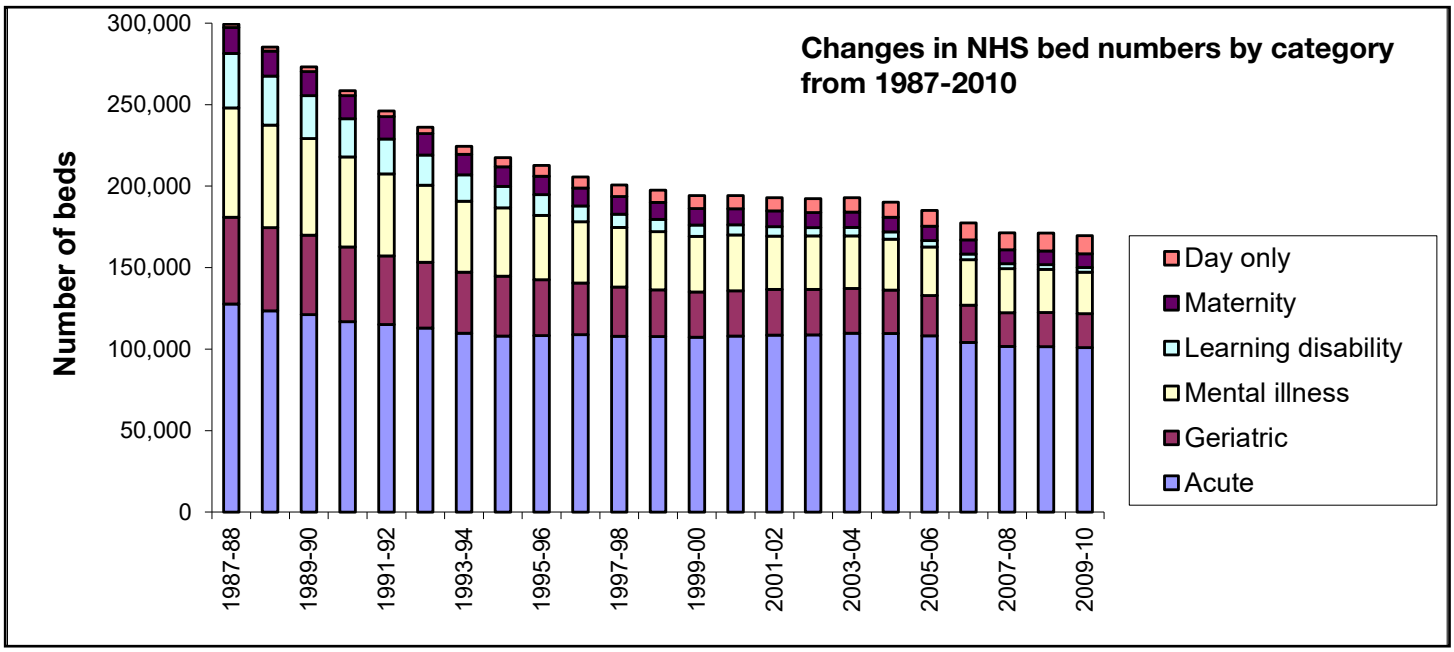
the biggest shift of policy in care of the elderly had gone through with little discussion in 1980.

The Social Security Act, endorsing a policy which began to be applied in 1979, gave DHSS offices the discretion to meet the costs of residential or nursing home care for elderly patients from the social security budget. At first only a trickle of patients from NHS hospitals were to receive care paid for in this way: but this was soon to increase to a flood .

Growing numbers of health authority and hospital chiefs spotted that this was the ideal means to shift the bill for caring for an expensive group of patients from their cash-limited NHS budgets onto social security: and they followed this by closing down the vacated NHS geriatric beds.

Business entrepreneurs with an eye to a profitable investment saw that private nursing and residential homes offered an attractive proposition; numbers of homes and places rocketed during the 1980s (nursing home places increased from 18,000 in 1982 to 150,000 in 1994: private residential home places expanded from 44,000 in 1982 to 164,000 in 1994), while NHS provision was rapidly reduced.

The procedure under the 1980 Act was made even speedier by a 1982 amendment to the Social Security



Act. Until then Social Security officials had only been empowered to make top-up allowances to the board and lodging allowance to cover residential or nursing home fees: the new system made this an entitlement.

Rapid privatisation

The process that ensued was one of rapid, unannounced and almost unchallenged privatisation. For the frail elderly, the concept of care free at the point of use and funded from taxation was rapidly disappearing.

More than half of the elderly people in residential homes were paying their own fees. Many of those who moved in to the dwindling number of council-run residential homes (which almost halved in number from 116,000 to 69,000 places over the same period) were obliged to pay for the privilege: 36% of the costs were being "clawed back" from residents through means-testing – paying charges totalling around £1 billion a year in the mid 1980s, eight times the annual revenue from prescription charges (Lister 1998:76).

But it was nursing homes which were set to become the biggest area of business growth. In 1979 it cost the DHSS £10m to finance 11,000 clients in nursing homes. By 1993, 281,000 people were receiving state-funded care in private homes, at a cost of £2.575 billion.

By the end of 1986 the Audit Commission was drawing attention to the scale of this spending, which was running out of control. Secretary of State Norman Fowler called in Sainsbury managing director Roy Griffiths to conduct an inquiry.

The resultant 1988 "Griffiths Report" (Community Care; Agenda for Action) proposed the transfer of responsibility for continuing care of the elderly from the NHS (where it was still provided free of charge at time of use) to local government (where it would be subject to means-tested charges). It amounted to the consolidation of privatisation and means-testing, with an end to the direct use of social security funding.

Response to Griffiths

A London Health Emergency (LHE) pamphlet (Community Care: Agenda for Disaster) responding to the report in September 1988 warned that

"We can hear the till bells ringing and the knife sharpening," arguing that imposition of means-testing (and thus cutting NHS expenditure at the price of increased charges on individuals, their savings and property assets) was the main driving force behind Griffiths' proposals, which were was quite explicit, arguing that: "Many of the elderly have higher incomes and levels of savings than in the past … This growth of individually held resources could provide a contribution to meeting community care needs." (6.61)

In 1987 the NHS had 127,616 acute hospital beds (handling emergency and elective care) and another 52,273 geriatric beds, giving a "general and acute" beds total of 180,889. 20 years later geriatric bed numbers had been cut by over 60% and acute beds by 20%, to give a total of 122,374.

As if to underline the financial agenda which informed his whole approach to the community care issue, Griffiths had little of substance to say about mental health services, which were to be left under the lead control of the NHS. It is a painful fact not lost on Griffiths that while many pensioners have savings and property assets which could be used to pay their own way, few psychiatric patients have sufficient wealth to make a similar approach worthwhile.

The Griffiths proposals implied even more wholesale privatisation, as they aimed to subject every aspect of community care services – whether residential or domiciliary – to "competitive tenders or other means of testing the market". They would also confine social services departments to the role of "purchaser" of continuing care.

80% of the government money flowing to social services had to be spent in the "independent" (private or voluntary) sector. There were measures to deter councils from providing their own residential care services for the elderly.

Strangely enough, however, these policies, commissioned and published by a government with a track record of attacking local authorities, had been enthusiastically greeted by many Labour-led councils and chairs of social services.

They seemed oblivious to the perils of what would later be described (in a rare political insight by shadow health spokesperson David Blunkett) as a "poisoned chalice", which would involve Labour councils in means-testing pensioners and forcing many of them to sell their houses to pay for care in profit-seeking private homes.

The clue was in the fact that Thatcher, no fan of local authorities, had been persuaded to agree to this switch, recognising that it would bring a substantial reduction in government spending, and leave Labour councils taking the blame for failing services.

Nonetheless a bizarre local government pressure group called "Griffiths Now" (dubbed "Turkeys for Christmas" by LHE) joined forces to lobby for the reforms to be introduced sooner! Shadow Health Secretary Robin

Continued overleaf, page 10

History of NHS Privatisation Part 2

Continued from page 9

Cook also raised questions in the Commons pressing for swift implementation of the Griffiths proposals.

Few people in health or local government had followed the issue closely enough to recognise the danger. The policy was widely presented in the press (notably the Guardian) as a progressive package of reforms.

LHE, which openly criticised the councils' campaign, and which spoke at meetings of health workers and pensioners warning of the implications of the Griffiths reforms, came under pressure for its hard line of outright opposition to every part of the package, and a number of councils cut their funding to LHE.

The government response to the Griffiths Report came in July 1989 with the publication of the White Paper Caring for People. Most of the Griffiths proposals were then incorporated into the National Health Service and Community Care Bill at the end of 1989, and Labour's already tepid opposition to the marketisation of health and community care was further defused by its acceptance of half of the new legislation.

Kenneth Clarke described the proposals in the Bill as "80% Griffiths". The missing 20% was significant.

Dropped were Griffiths' proposals for a separate minister for community care, and for the money transferred from social security to local government budgets to help pay for placements to be "ring-fenced" to ensure transparency and prevent it being used for other purposes. Also gone was Griffiths' call for additional cash for community care.

However the government recognised the potential disruption that could be caused if the reforms were introduced in 1991, alongside the new internal market proposals set out in the remainder of the Bill.

So although the legislation was to be pushed through Parliament in 1990, the date for implementation was pushed back to 1993, meaning that the first new means-tested charges would be imposed comfortably after the next election.

White Papers

In January 1989 the White Paper, Working for Patients was launched with a lavish £1.25m nationwide press and TV extravaganza, including a scary video featuring Margaret Thatcher made clear the government was pressing forward with plans to "reform" the NHS.

Swiftly renamed "Working for Peanuts" by staff and "Working for Profits" by campaigners, the new plan embodied elements of many of the nostrums put forward by backwoodsmen and think tanks, but relied heavily on the concept of an "internal market" which had been advocated in a 1985 paper by an influential figure in American health care, Alain Enthoven.

Central to Enthoven's approach was the allocation to health authorities of budgets calculated on a per capita basis: the HAs would then be free to buy services for local residents – either from each other, or from the private sector: his model was the US Health Maintenance Organisation, a device to regulate the ruinously expensive private healthcare sector which appeared to succeed in that objective for a few years in the mid-1990s.

Enthoven was one of the many economists, politicians and academics seeking ways of "managing" the chaotic and ruinously expensive private market in health care in the USA.

His proposals aimed to restrict the costs of private medical insurance – and therefore reduce premium payments for individuals and for corporations – through the introduction of "managed care", offering a restricted choice in the form of a defined range of funded treatments from a restricted range of "preferred providers" with whom specific deals would be done (Enthoven 1978).

Indeed Enthoven later went further, and argued in 2002 that excessive market freedom in the hands of health service users could undermine the market tools in the hands of the insurance companies, who would use their power to purchase in bulk as a means to hold down prices, arguing that free choice of provider destroys the bargaining power of insurers.

Although the community care legislation was to be pushed through Parliament in 1990, the date for implementation was pushed back to 1993, meaning that the first new means-tested charges would be imposed comfortably after the next election

Internal market

The Thatcher proposals stopped well short of the root and branch "privatisation" or attack on the essence of the NHS that some had feared; but it did begin to remodel the NHS itself, dividing it into purchasers and providers, in an "internal market".

For secondary care the main purchasers would be District Health Authorities, with funding allocated on a complex formula to take account of the age profile and social circumstances of their population.

Health authorities themselves would be drastically reshaped to look more like businesses: numbers of HA members would be cut from an average 18 to just 11 – but this reduced number would include five "executive members" (NHS managers, who had not previously had formal positions on health authorities).

Each HA would have a chair appointed by the Secretary of State, and paid £20,000 a year for part-time involvement, and five "non-executive" members, paid £5,000 a year, also selected by ministers.

Through these payments the government's control over the network of quangos through the power of patronage was strengthened.

A second type of purchasers would be GPs: bigger practices would be urged to take responsibility for cash-limited budgets, from which they would buy non-emergency hospital treatment for their patients – from local NHS hospitals or if they chose, from the private sector. GP budget-holders were swiftly renamed as "Fundholders" to avoid concerns that their budgets would run out.

The "providers" – the hospitals and community services – would initially be separately managed in an arm's length

relationship with the health authorities, but they would increasingly be encouraged to "opt out" of health authority control as "self-governing" hospitals (later renamed as "NHS Trusts" in an attempt to overcome complaints that they were effectively "opting out of the NHS").

Hospitals would be obliged to compete against each other for contracts from health authorities and GP Fundholders: the claim was that in this way money would "follow the patient", rewarding the hospitals which best succeeded in meeting local requirements, with an all-round extension of "choice" and a downward pressure on costs.

Competition in the NHS

The notion of competition was not popular in the NHS. Many hospitals were still smarting and showing the scars of the "competitive tendering" of ancillary services, in which the lowest-priced tender had almost always been taken.

There were legitimate fears that, as with the tendering exercise, the "competition" would make only ritual nods in the direction of quality of care, and overwhelmingly centre on the issue of price: it would also lead to a further round of cost-cutting, which in turn, with labour costs still representing 70% of NHS spending, implied a fresh attack on staffing levels, pay and conditions.

Competition also brings losers as well as winners. Less-favoured hospitals which lost out to rivals for major contracts would also lose contract revenue. Those determined to steal away contract income from rival hospitals might decide to concentrate on a few, potentially lucrative services, at the expense of closing others.

With health authorities already beginning to run down their provision of elderly care and mental health beds, it did not take a genius to work out the likely areas that were likely to be scaled down.

Critics of the proposals asked whether it was purely by coincidence that the new system was to establish a comprehensive apparatus for pricing and billing for individual episodes of treatment – that that this same apparatus could be subsequently used by a future government to impose means-tested charges for care, in a possible move towards an insurance-based, privatised service.

GP fundholding

The proposal of GP Fundholding also brought in cash limits on primary care services for the first time.

While opponents of the scheme asked what would happen when a fundholding practice ran out of money, a handful of GPs were lured by the lavish cash incentives, the chance to break away from the narrow confines of services dictated by their local health authority, the opportunity to negotiate preferential deals for their patients to secure more rapid treatment at selected hospitals (opening up a two-tier service within the NHS), and in some cases the possibility of buying services from the private sector.

Another attraction for the most grasping GPs was that they would be able to retain within the practice any surplus left over from each year's budget.

One fundamental problem critics found with the introduction of fundholding was that it created a new uncertainty in the patient-doctor relationship.

No longer could a patient be certain that decisions were being taken solely in his/her interests: now the financial situation of the practice, even the personal financial gain of the GP, could be seen as a possible factor underlying a decision.

The vast assets of NHS land, buildings and equipment would increasingly be "owned" by the Trust Boards, which would have the power to sell off surplus assets.

There was a suggestion that self-governing hospitals would have the freedom to borrow money from the government or from the private sector – this proved to be one of the most misleading promises, as Trusts found themselves constrained from day one by rigid cash limits.

To make matters worse, Trusts were required to pay interest ("capital charges") on half of the book value of their assets. This served primarily as an incentive to push Trusts into selling off spare property assets in order to escape capital charges – and later paved the way for the funding of new hospitals through the Private Finance Initiative.

Other promised "freedoms" for Trusts included the right to expand private wings and numbers of pay-beds, and the right to decide "local" pay and conditions for Trust employees – tearing up the long-established Whitley Council system of national-level agreements underpinning all grades of staff.

In return, Trusts were to be obliged only to balance their books and show a return on assets of 6% each year: any retained surpluses could be ploughed back into services. But of course any losses would also be the sole responsibility of the Trust, and the reforms carried the underlying threat that a failing Trust could go bankrupt. Ministers insisted from early on that they would not bail out Trusts which failed financially.

The Thatcher government was not one to hold back for fear of public opinion, and the polls showing almost 75% of voters and more than half of all Tory voters to be opposed to the reforms did not prevent the proposals being pushed through Parliament as the NHS and Community Care Bill.

Polls showing almost 75% of voters and more than half of all Tory voters to be opposed to the reforms did not prevent the proposals being pushed through Parliament as the NHS and Community Care Bill.

So even as Thatcher herself, paying the price for the mass rejection of her Poll Tax policy, was ousted from office and replaced by John Major, the legislation was pushed through.

The first NHS Trusts began operations in April 1991 – with a massive package of redundancies at Guy's Hospital – and the unstable years of the internal market began.

Next in this series:
Enter PFI and private clinical providers

This is a new feature in *The Lowdown*, in which we invite observers and campaigners to air their own views on an NHS-related topic of their choice

Do like the Romans do …

Comment column from ROY LILLEY - received on March 10, before the change of government policy

I'm going to confess something. I've never eaten a Pizza.

They look like a traffic accident on a plate. I just can't bring myself…

On the other hand, pasta, ragout, chianti. I'm yer man. Ferrari cars, Georgio Armani, the beaches of Sardinia, opera, Borsalino hats and when in Venice, tucked in a side street, not far from San Marco, Cristina Linassi's silk and lace.

Oil from Tuscany, cashmere shawls and did I mention wine? Yes, I think I did.

And, their healthcare system isn't too bad either. It's modern, routinely ranked as one of the best in the world, access is good, overall quality is good and the general health and life expectancy of the population is very good.

The system is free to use. They have GPs and you can change who looks after you. They spend about 9% of their GDP on healthcare.

So, when I read in the press and see on the telly, the Italian healthcare system is in Corona-virus trouble, I pay attention.

When I see Italian patients being ventilated on beds, in corridors, I start thinking. When I read, on Twitter, Italian doctors and nurses are exhausted, I take notice.

When I'm told up to 15% of Coronavirus cases are likely to need intensive care and the Italian system is overwhelmed, I sit up straight.

There's a lot we must learn from Italy.

Not China. The response of a totalitarian state, their management of news and manipulation of data tells us little that is reliable.

When Italy, whose version of the NHS is on a par with ours, are at the point where they've stopped closing-down towns, given up closing cities and decided to shut the door on the whole country, it makes me ask a simple question…

What is Italy telling us, and if I was BoJo, what would I be doing differently?

Right now, the message here is; listen to the experts and follow the science.

Experts… is there a more reassuring man than Chief Medical Officer, Prof Chris Whitty, the nation's uncle? The reassuring manner of an airline captain announcing we have landed safely. If he were a ballroom dancer, he would be a champion, gliding the floor, to a waltz. If he were a car, he'd be a Bentley.

On the other hand, BoJo looks like he's slept in his suit and is out of his depth. The PM is a man made for japes and jibes: he's not built for serious or sober.

He says he'll follow the science, but that does not absolve him from making some serious decisions.

The rightness, or otherwise, of serious decisions, are judged by history.

Will he be remembered as the man who saved the corona-economy from a crash, or the man who saved 300,000 corona-infected lives?

What would I do differently?

I'd certainly sit at the feet of the Prof and listen to every word. But, by now I would have, in place, a simple subsistence system, for people who are on insecure contracts, to draw money to keep their families and households going, through self-isolation.

By now I would have stopped football matches… sorry.

Closed theatres, sorry, sorry. Shut down the London Tube… very sorry, sorry and make all but essential personnel work from home.

I would ban all but vital travel, make arrivals into the UK self quarantine for 14 days and send uni-students home. They could look after their grannies.

I'd close the schools.

As for the Secretary of State's idea of a Dad's Army of volunteers, supposedly coming back to work in the NHS… no thanks.

They are mostly at the age where they are vulnerable to infection. Best use them to befriend and look after elderly people in their own homes.

All these measures will have to be taken in the next three or four weeks.

BoJo wants to keep the economy going for as long as possible but there are no effective, workable public-health restrictions that do not impact on the economy.

My view… in the modern context, ask; what did the Romans do for us?

They showed us what's next. Gave us a glimpse of the future.

We may not be in Rome, but we should do like the Romans do.

When I read in the press and see on the telly, the Italian healthcare system is in Corona-virus trouble, I pay attention.