THE lowdown

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

One constant in midst of Covid crisis: private sector cashing in on contracts

John Lister

It's becoming increasingly difficult to keep pace with the rapid changes and abrupt U-turns in government policy on how to deal with the Covid-19 crisis.

The past fortnight has seen repeated U-turns on requiring the use facemasks, both in public transport and in NHS settings and care homes, along with varying figures on the R level – at local and national level – whether it was going up or down, and whether or not the alert level should be reduced from four to three.

Ministers justified relaxing the lockdown on the "world-beating Test and Trace" system they insisted would be in place by 1st June, only for an email from the head of the Test and Trace programme to reveal the next day that it would not be operational until September, while leaks revealed the poor level of training of the majority of test and trace staff.

Constant pressure to privatise

But one constant in this ebb and flow has been the growing and determined focus of ministers on bringing in management consultants to run services and private companies to do vital jobs that should properly be done by the NHS or by local government, including supplies of PPE.

Perhaps the most blatant example recently brought to light has been the decision back in April to award a mega £108m contract for procurement of PPE to PestFix, a family-run pest control company with just 16 employees and assets of £18,000.

The Times has also highlighted the award of a £2m contract to Double Dragon, a small company with a phone number does not work and business premises on a residential street in Ilford, which describes itself as a wholesaler of coffee, tea, cocoa and spices. It is now claiming to be a certified supplier to the NHS of medical-grade equipment.

NHS England and Matt Hancock see continued block booking of private hospital beds as central to their plans to resume elective treatment

Testing site contracts

Contracts to set up Covid-19 testing sites have been awarded to city analysts Deloittes, and sub-contracted to Serco, Sodexo, G4S, Mitie and others.

And the contract of up to £90m for running the vital track and trace system has been entrusted to Serco once again – a company with a long track record of contract failures, but Winston Churchill's grandson as CEO and former lobbyist Edward Argar now a health minister.

A petition demanding Matt Hancock removes Serco and puts track and trace into the hands of experts in local government and NHS professionals has been launched by We Own It.

There have also been angry complaints at the profitable contracts handed out to develop the unproven track and trace app, and the even more questionable contracts which are handing over or opening up NHS data to other tech companies including Palantir, Faculty, Amazon, Google and Microsoft.

Meanwhile as we have warned in ***The Lowdown***, it's becoming increasingly clear NHS England and Matt Hancock see continued long term block booking of private hospital beds as central to their plans for the NHS to resume limited provision of elective treatment – while upwards of 30,000 NHS beds remain closed.

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Do shielding changes leave thousands exposed?

As the death rate finally falls across the country, the government has rapidly switched the advice for the most vulnerable patients who have been shielding indoors, but in some areas the rate of transmission is rising and in others deaths are not falling as fast, so should guidance to shielding patients be more nuanced?

Just three days before the change in government advice, an analysis by the Telegraph of latest Office of National statistics data found 18 council areas that had not yet passed the peak of weekly deaths, including Carlisle, Doncaster, North Somerset and Herefordshire.

Lowdown researchers matched these hot spots with data from NHS digital to reveal that 87,835 patients in England shielding under government guidance, were now being told that they can venture outdoors, despite the relative differences in risk between areas.

The newest research about the rate of transmission by Public Health England (PHE) and Cambridge University suggests the R rate is on the rise in some regions and is now at around 1 for the south-west and just over 1 for north-west England.

Seeing the country-wide death rate fall was one of the key triggers in the government's decision to loosen the lockdown, but the fact that hot spots in transmission exist has led some to call for a more local response.

Anthony Costello, professor at University College London and a former director of maternal and child health at the WHO said:

"We need to devolve power and autonomy to allow locally intelligent decisions around a coherent national strategy"

Despite a localised response in response to a spike in cases in Weston Super Mare the government is still offering the same blanket guidance across all areas

However leaders in Northern Ireland and Scotland took a different view, and their shielding advice did not change.

New data is also now making regional differences more apparent: in all regions the rate of deaths is still falling, with the exception of London and the South west where the number of deaths in hospitals is stable.

The rate of deaths in care homes is also falling. Researchers at University College London have warned that the number of vulnerable people may be higher than 2.5 million currently shielding. Lifting the restrictions too early could lift the death toll to 73,000.

Senior author, Professor Harry Hemingway said: "Our findings emphasise the importance of delivering consistent preventive interventions to people with a wide range of diseases."

Council (England)	Numbers shielding
Ashford, Kent	4660
Broadland, Norfolk	6185
Carlisle, Cumbria	3665
Doncaster, South Yorkshire	17145
Eden, Cumbria	2320
Fenland, Cambridgeshire	4605
Herefordshire	7860
Hinckley and Bosworth, Leicestershire	4030
Kettering, Northamptonshire	3590
North Somerset	7540
Preston, Lancashire	4140
Richmondshire, North Yorkshire	1485
Rother, East Sussex	3690
Selby, North Yorkshire	3245
South Norfolk	6785
Tonbridge and Malling	3470
Wyre Forest	3420
	87835

Source: NHS Digital Table of councils with death rates yet to fall

Patients and staff left confused by rushed changes

Last week the government announced that people currently shielding due to a variety of medical conditions could now leave their homes. The announcement, which hit the headlines the next morning, came as a complete surprise to England's GPs and to NHS England.

NHS England's head of primary care, Dr Nikita Kanani, tweeted that "as soon as she knew more, I will post on this thread. In the meantime continue to follow the guidance."

There are around 2.2 million people who have been shielding since March. These are patients who are considered to be particularly vulnerable to the virus and they were advised to take stringent measures to prevent the infection entering their homes and not to leave their homes until 30 June.

The new guidance says that clinically extremely vulnerable people can now leave their home and meet with one other person, as long as they are able to maintain strict social distancing.

GPs and charities were both angry at not having been informed in advance about the changes to the guidance and concerned about the chaos and confusion that it will sow among patients. The suddenness of the announcement means that they have had no time to prepare advice for worried patients.

Bolt from the blue

The specialist charity, Blood Cancer UK, said the news came as a 'bolt out of the blue' and that the government's handling of the situation has added to the worry in its community. The charity criticised the way the changes were announced late on a saturday night with "no warning or consultation with charities or clinicians" which has "created confusion."

Even before this announcement,

charities had become exasperated at the lack of communication for shielding groups, with millions of vulnerable and extremely vulnerable people getting mixed and confused messages.

A group of charities, including Macmillan Cancer Support; British Lung Foundation and Asthma UK; MS Society; National Voices; Versus Arthritis; Kidney Care UK and Cystic Fibrosis Trust wrote an open letter to the government 28 May asking for more clarity and better communication.

Shadow health secretary Jonathan Ashworth said it was "an utterly irresponsible way to treat highly vulnerable people worried about their personal health."

Other medical professionals took to social media to voice concerns, with one GP anticipating "chaos" on monday and another who works with cystic fibrosis patients noting that clinicians in secondary & tertiary care working with shielding groups had also not received any communication and they were expecting a lot of queries and anxiety from their patients. Another GP tweeted, tongue in cheek, that could all patients send queries to Matt Hancock as GPs hadn't been told anything about the changes as they obviously weren't important enough.

The lack of communication with GPs, was tackled at the 1 June briefing by Jaimie Kaffash, editor of ***Pulse***.

He asked Secretary of State for Health and Care, Matt Hancock, why the advice for shielders had been rushed through before patients and GPs understood it?

"Cautious changes"

Hancock denied the changes had been rushed through saying the "cautious changes" had been worked on "for some time" and "once we made that decision…. we then communicated that decision and this was the right time to be able to change that advice."

This didn't really answer the question of why the media knew the change in guidance from a press release before the GPs.

They had only just received NHS England's updated Standard Operating Framework on the night before the changes went public. It said all shielding patients should have a named clinical lead - but did not mention the changes announced just a day later.

Charities and GPs report that patients are puzzled, as are they, about what prompted the change in advice.

Asked this at the same press briefing, Hancock stated "One of the reasons that we could make that change is that the rate of incidence of the disease is now back down to the levels that it was before we introduced the shielding policy."

A GP tweeted, tongue in cheek, asking all patients to send queries to Matt Hancock as GPs hadn't been told anything about the changes as they obviously weren't important enough

The change in guidance does, however, seem at odds with the current threat level of level 4.

All four of the UK's chief medical officers (from England, Northern Ireland, Scotland and Wales) are reported to have rejected plans from Downing Street to lower the virus threat level due to evidence that the virus was still widespread.

Alert level

The virus alert level has remained at 4. The easing of some lockdown restrictions and the changes to the shielding guidance were only supposed to take place when the threat level had reduced to 3 or below. When asked, the Foreign Secretary Dominic Raab told Sophy Ridge on Sky News that we are "transitioning from level four to level three".

The Association of Directors of Public Health (ADPH) do not agree with the government's move on easing restrictions and have said it is "increasingly concerned that the government is misjudging the balance of risk between more social interaction and the risk of a resurgence of the virus, and is easing too many restrictions too quickly".

They urged ministers to postpone the easing of restrictions until more is known about infection rate and a test and trace system is more established.

Caution was also urged by the Royal College of Nursing Dame Donna Kinnair, the chief executive and general secretary of the Royal College of Nursing, said staff were "anxious that easing lockdown could undo the progress we've made as a country in combating this virus".

Targeted measures

Should infections surge, the government has said that there is a possibility of geographically-targeted measures, such as locking-down specific cities. The ability to do this will, however, be impaired by the loss of public trust engendered by the Dominic Cummings affair.

The ADPH letter noted that "a relentless effort to regain and rebuild public confidence and trust following recent events is essential," for lockdown restrictions to be lifted; which can be viewed as a reference to the Cummings situation.

Such an effort will also be needed if geographically-targeted lockdowns need to be put in place.

Doubling up on 111 service? **Berkshire Trust latest to sign up for Babylon's triage app**

In mid-May private healthcare company Babylon Health was awarded its third contract by a hospital trust for use of its Ask A&E triage tool, but critics are questioning the expenditure as it appears to duplicate the existing 111 service.

The contract with the Royal Berkshire Foundation Trust is for 12 months and will cost the trust an undisclosed amount, but the deal could mirror longer term partnerships that Babylon has with the Royal Wolverhampton FT and University Hospitals Birmingham FT.

Under the system patients can input their symptoms into the Ask A&E tool, now available online via the trust's website. It provides advice to the patient based on symptoms, which could include going to A&E, calling an ambulance, seeing a GP, or staying at home and monitoring symptoms.

Nothing extra to 111

However it appears that the software doesn't offer anything more than the current NHS 111 service, which is already available in the Thames Valley area - part of an integrated urgent care service operated by South Central Ambulance Service NHS Foundation Trust (SCAS) in collaboration with Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust and Buckinghamshire Healthcare.

Umang Patel, Babylon's director of NHS services, told HSJ that the system "doesn't differ massively but it's more the process of getting to that information." He added that "111 is more orientated to phoning up a number and looking for an immediate solution, and that's designed to take pressure off the 999 service…..We're trying to help people use a more sustainable resource for self-help, which they can use at their own pace."

Since the NHS 111 service can also be accessed online, and from the NHS app you can message your own GP, the 'Ask A&E' tool actually provides a lesser service than NHS 111.

"Trusted way to get information"

Trust chief executive Steve McManus said in Babylon Health's press release: "With 111 being extremely busy at the moment, the Ask A&E service offers a trusted way to get information from the NHS."

The existing NHS 111 contract was set up by Berkshire Commissioners in 2017 and promised that:

"Thames Valley 111 will now offer patients a seamless 24/7 urgent clinical assessment and treatment service – bringing together NHS 111, GP out of hours and other clinical advice, such as dental, medicines and mental health."

Add to this, the fact that the NHS 111 service can also be accessed online and from the NHS app it's also possible to message your own GP, it would appear that the Ask A&E tool actually provides a lesser service than NHS 111.

Comments under an article on the contract on HSJ highlight the duplication of service, including noting that if a CCG commissioned this service, it would then have to decommission the NHS 111 service currently running as it would be a duplication.

The cost of the contract has not been published, but a freedom of information request has been sent by NHS Support Federation researchers asking for disclosure of the cost of this contract.

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





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

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

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

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

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

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

Our supporters have already helped us to research and expose:

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

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

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

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

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

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

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

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

Every donation counts!

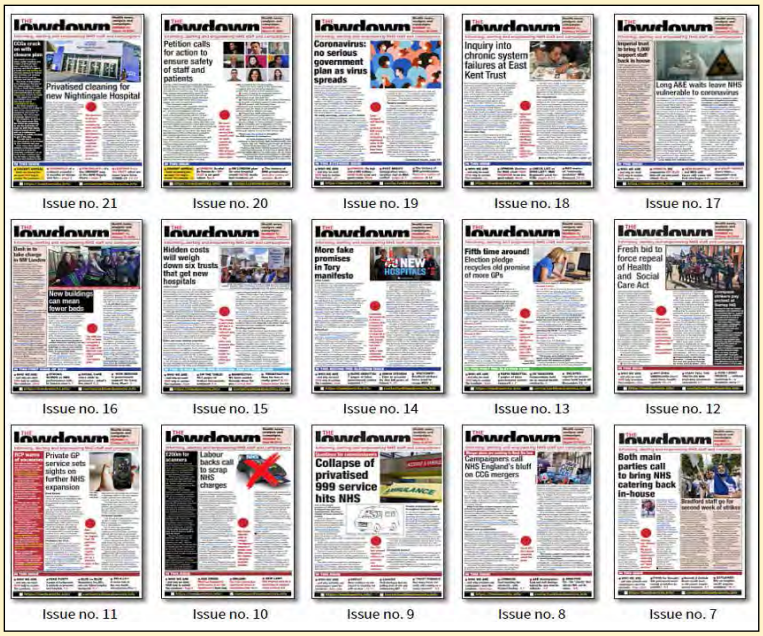
We know many readers are willing to make a contribution, but have not yet done so.

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

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

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

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



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

Integrated care systems

In 2016, NHS England brought NHS organisations and local councils together to form 44 sustainability and transformation partnerships (STPs) covering the whole of England….

In some areas, these partnership are seeking to evolve to form an integrated care system, in which, "NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve."

The NHS Long Term Plan in 2019 declared that ICSs would "cover the whole country" by April 2021.

However neither STPs nor ICSs have any legal status under the controversial 2012 Health & Social Care Act.

Clinical Commissioning Groups (CCGs) are the statutory local bodies controlling the budget for health care to cover the needs of their population. NHS England has been pressing for the merger of CCGs:

In April 2020 74 existing CCGs merged to establish 18 new ones, reducing the total number of CCGs to 135. ICSs have no legal powers – or accountability to local communities. In May 2020 4 more ICSs were set up, bringing the total to 18.

What's happening o

John Lister

Never has there been a clearer argument for the proper integration of NHS services and integration of NHS with local government services than the current Covid-19 pandemic.

Yet there is precious little evidence that changes that are being passed off by NHS England as "integration" are anything more than a flimsily concealed drive for greater centralisation and reduced local accountability.

In the aftermath of recent revelations in the Lowdown and the HSJ of plans by NHS England's regional office to impose a 'fundamental' overhaul of the NHS in the capital, Greater London Assembly member Onkar Sahota has written to the mayor of London to express his concern over "the seemingly advanced stage of planning" for a new system "without any documents being released, let alone consultation with Londoners".

And recent analysis in the HSJ suggests that NHS England is taking advantage of the current situation (and the lockdown) to drive forward with its restructuring:

"turbo-charging some of the key structural changes and integration which were envisioned, and towards which the NHS had been trying to drag itself for several years."

Signs of life? A survey of ICS websites

South Yorkshire and Bassetlaw

Although it has some recent, general, press releases, and a Covid blog, the website of this early ICS shows that the Collaborative Board has not met since October 2019. The ICS performance link is to a 2017 NHS England Dashboard.

Frimley Health and Care

This ICS website has recent press releases on general topics but no reference to partnership board or ICS level decision making. The most recent newsletter boasts a message from Andrew Lloyd, Chair of the Frimley Health and Care ICS Board which begins "As we approach Christmas and the New Year".

Dorset

No apparent "Latest News" on this website since January, when the main focus was on celebrating the decision of the Independent Reconfiguration Panel to overrule objections from local campaigners and rubber stamp the downgrading of Poole Hospital's A&E to focus all emergency services in the south of the county in Bournemouth.

Bedfordshire, Luton and Milton Keynes

This was an early ICS, but its bland Partnership Board papers from March 2020 give no sign of anything happening other than vague discussions. "Bimonthly" ICS Briefing not published since July 2019 – long before Covid-19 could be used as an excuse.

Nottinghamshire

This appears to be the most serious of the ICS websites, with a monthly schedule of meetings up to March that appear to include some detailed financial reports in their papers (along with many pages of much more general and unfocused material that appear to simply restate the obvious in more complicated ways).

Lancashire and South Cumbria

The website makes clear that while "The role of the Integrated Care System (ICS) Board is to provide leadership and development of an overarching strategy for Lancashire and South Cumbria, oversight and facilitation of the delivery of sustainability, transformation and design of the future state of health and care,"

"The ICS Board does not meet in public and the papers are not publically available, at this time. However the ICS Board will review this again in 2020." Tucked away is an admission of a £200m funding gap for 2019/20.

"The ICS Board does not meet in public and the papers are not publically available, at this time. However the ICS Board will review this again in 2020."

Buckinghamshire, Oxfordshire and Berkshire West

An annoying website with lots of sliding and zooming panels is still promoting a September 2019 response to the NHS Long Term Plan and a January 2020 "engagement report" which lists, rather than responding to, public views on plans for a single CCG to cover the ICS area. The website and a governance chart appear to show this ICS has not even the pretence of a Partnership Board, and relies on "a lean and agile BOB ICS operational team".

Greater Manchester (devolution deal)

The Meetings and Events page simply states "Sorry there are no meetings or events". It appears that there was a meeting in January, although little of any consequence is revealed from the Agenda, with no papers attached: the most recent minutes are from October 2019. A resources page has a range of videos on coronavirus and other topics.

Surrey Heartlands (devolution deal)

'News' on this largely empty website runs up to May 12 2020, but there is no information on any partnership or other board structure or any meetings or board papers – in public or otherwise.

The Strategy statement promises: "We recognise our strategy will be constantly evolving and intend to update this document in autumn 2019 following submission of our five year plan to NHS England (which details how we will be implementing the NHS Long-Term Plan)."

This ICS is one of **TWO** ICSs covering the Epsom & St Helier hospital Trust, which serves the population of the former Surrey Downs CCG, and is engaged in their own plan for a new £500m acute hospital in Sutton that would

on Integrated Care?

For several years the rhetoric of NHS England has echoed with references to integration, more recently the establishment of "Integrated Care Systems," (ICSs) which according to the Long Term Plan are supposed to cover the whole of England by 2021 – despite the fact that they still lack any statutory powers or legitimacy.

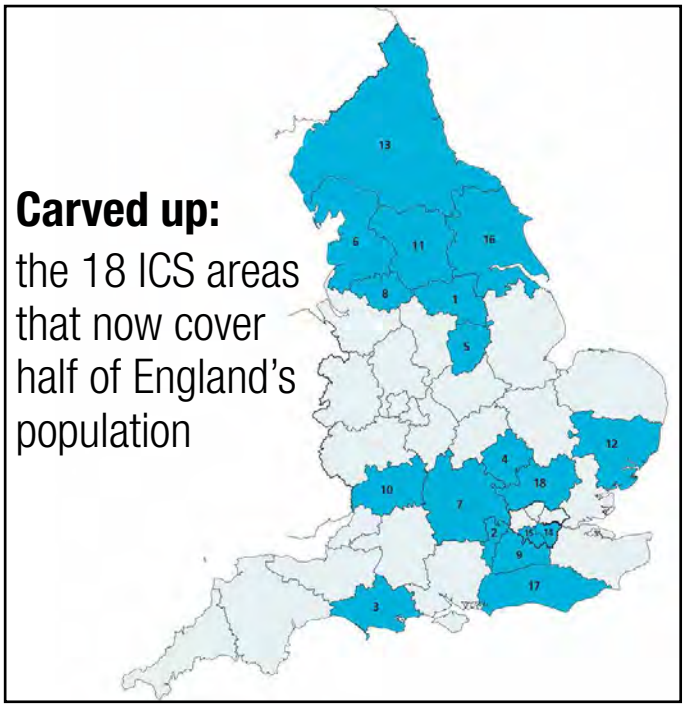
On May 11 NHS England boasted of the way it was beginning to "lock in" changes that had been pushed through as part of emergency measures to cope with coronavirus:

"The NHS and its partners will be able to 'lock in' improvements to their work by putting whole-system planning at the heart of coronavirus recovery plans, the NHS's Chief Operating Officer said today."

The same statement revealed NHS England and NHS Improvement have rubber stamped four new 'integrated care systems', "together serving more than six million residents."

The new ICSs, which join 14 previously announced and two 'devolved health systems' in Greater Manchester and Surrey, are Humber, Coast and Vale; South West London; Sussex and Hertfordshire and West Essex. As a result "around half of England's population" is now covered by an ICS, including the

Continued overleaf page 8



Carved up: the 18 ICS areas that now cover half of England's population

almost halve numbers of acute hospital beds, and be much less accessible for Surrey residents.

Gloucestershire

A relatively lively site which links in to Gloucestershire County Council has up to date news and press releases, mainly on social care, and no info on the work of the ICS.

West Yorkshire and Harrogate

This website is one of the few with visible evidence that the ICS Health and Care Partnership Board is functioning, although recent meetings are understandably focused on Covid, and the looking forward document is predictably vague. It has a dauntingly huge list of Priorities, and some recent blogs: but its Next Steps document dates back to 2018!

Suffolk and North East Essex

This ICS has hilariously taken the street name of **"Can Do Health and Care,"** although it appears it hasn't done any Board meetings since April 2019, and its most recent News Update was last October. Resources include some generalities on the ICS, and a 'Winter 2018/19 Communications Toolkit'.

The North East and North Cumbria

The March 2020 Board Agenda and Papers noted that most of Objective 10 (Deliver improvements and innovations for elective care) was "off track" – but contained no finance report.

South East London

No meeting or papers since January. Financial papers show aim to cut spending by £0.9 billion, through measures impacting on providers, but link back to 2016 STP

South West London

Only a limited website so far for this new ICS covering Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth, and offering a link to its 2016 Sustainability & Transformation Plan, which declares:

"South West London STP will continue to need all of the hospitals it currently has, but does not believe that every hospital has to provide every service. … The immediate focus is on getting primary care and services in the community right."

However this ICS is one of **TWO** ICSs covering the Epsom & St Helier hospital trust, which is engaged in a separate plan for a new £500m acute hospital in Sutton that would downgrade Epsom & St Helier hospitals, almost halving numbers of acute hospital beds, and cause knock-on impact in neighbouring SW London hospitals, especially St George's and Croydon .

One ICS has hilariously taken the street name of "Can Do Health and Care," although it appears it hasn't done any Board meetings since April 2019

Humber, Coast and Vale

A huge banner instruction to 'Stay Alert' as you land on this ICS website is not backed up with much an alert person can do, or any information on Partnership Board or equivalent meetings, papers or discussions.

The Upcoming Events slot is equally unhelpful, with no past or future content.

It's not clear whether anything is happening behind the scenes, but obvious nothing is being done in public view.

Sussex

The NHS England link is to the largely defunct old STP website: a search for Sussex Integrated Care System goes to a different website which is less out of date but makes no reference to the ICS.

The most recent Programme Board papers relate to early 2018 STP meetings.

Hertfordshire and West Essex

The NHS England link is to the largely defunct old STP website: a search for Hertfordshire and West Essex ICS takes us to a website that reports the STP has been given 'Integrated Care System' status.

However the 'STP System Leadership Arrangements' give no indication of plans for any Board to be established, let alone Board meetings in public or board papers published.

The website makes no pretence of seeking public involvement or consultation.

What's happening on Integrated Care?

from page 7

whole of Yorkshire and all of London south of the river.

Many of these changes, accompanied by widespread mergers of local Clinical Commissioning Groups to create ever-larger and less locally responsive organisations holding the purse strings for NHS services (in line with the call by NHS England for there to be normally just one CCG per ICS) have been made with little or no engagement with local people.

Moreover we should not underestimate the extent to which they are also simply blather and bluster to conceal little or no actual integration or cooperation at local level.

No need for ICS

All of the examples of partnership working quoted by NHS England last month, far from making the case for ICSs, in fact show that wide-ranging collaborative initiatives can be and have been carried through successfully prior to, and without establishing an ICS:

- a vascular services network involving hospitals in Hertfordshire and West Essex;
- helping to train and recruit more than 300 advanced clinical practitioners, nursing associates and physician associates in Humber, Coast and Vale;
- improved mental health support for around 80,000 school and FE college pupils in South West London,
- and "improved performance against the national A&E four-hour target by 1.2 per cent during 2018-19" in Sussex)

NHS England also claims in the same press release that Integrated care systems (ICSs) and, in other areas, sustainability and transformation partnerships

"have been central to the coordination and delivery of the response to the Covid-19 epidemic, bringing together hospitals, care homes, GPs and others to plan for immediate and future needs."

No role played by ICS

But there is little or no evidence from the ICS websites linked to these claims that the ICSs have played any role at all in these developments, which have taken place across the country whether or not an ICS has been in place.

Indeed there are few signs of life at all on many of the ICS websites, some of which – despite prominent tabs misleadingly labelled "Get Involved" – have no entries more recent than summer 2019.

Local government ignored

Most ICS websites also consistently show that the involvement of local government is either non-existent, or a token add-on to other collaboration between NHS organisations.

In South Yorkshire and Bassetlaw, for example, the ICS website describes a "System Health Oversight Board", as "a joint forum between Executives and Non-Executives from NHS England, NHS Improvement, other national arms' length bodies and health providers, health commissioners."

It also refers to a "System Health Executive Group - a monthly meeting of Chief Executives, Accountable Officers and other health partners".

And then it adds:

"We also continue to work with our Local Authority partners to inform and shape how our system health and care partnership arrangements might be organised."

The Lowdown's fearless investigators have tirelessly trawled through all of the websites for the 18 ICSs, to find only a small minority showing any signs of life, or any pretence of transparency or public accountability.

If NHS England is, as the ***HSJ*** suggests "turbo-charging" its progress towards a full roll-out of ICSs, this is being done without any process of public engagement, and behind a veil of largely dormant and irrelevant websites.

Glimpse of the future

In a way of course this is preparing the public for the minimal level of accountability that is likely to prevail when the full network of ICSs, still lacking any legal status or legitimacy, takes over control in all 42 "footprints" across the country next spring, removing all of the key discussions and decisions about the future of local services from public view.

Meanwhile local council scrutiny bodies, many of which have remained locked down – weeks after local commissioners, NHS England Regional directorates and other NHS bodies have begun to meet online and push forward with their agenda – need to step up their game.

They must 'stay alert if they are to stand any chance of holding local NHS chiefs to account.

No sign of bold vision in Lancs & South Cumbria ICS

John Lister

Lancashire and South Cumbria ICS has produced a Business Case for addressing chronic weaknesses in delivery of Individual Patient Activity – which reaches in to social care.

But the document does not appear on the ICS website, and makes almost no reference to local government at all, raising the question of whether it is even being discussed by councils.

It can be found tucked away in the papers of the eight CCGs within the area, and is remarkable as a paper for a number of reasons, not least the fact that an Integrated Care System seems to require a 60-page document to make the case for spending an extra £770,000 per year (an increase of 0.35% on a £200m-plus budget) to address serious and long-standing gaps and delays in care.

Modest ambition

From the outset the ambition is modest to say the least – to do what many people might have thought NHS Commissioners were there to do from the beginning:

> "This business case sets-out an ambition to transform the way we work, supporting individuals presenting with health and social care needs to access the most appropriate care."

It goes on to admit that this has not been the case at least since 2013:

> "The JCCCG has acknowledged that the current level of Individual Patient Activity services provided across Lancashire and South Cumbria (with the exception of Blackpool) is providing standards of care that fall well below an acceptable standard and should be of concern to all CCG Governing Bodies."

However it clearly has not been a concern to 7 of the 8 CCGs, who have been falling short for years (the exception is Blackpool, where CCGs chiefs have worked with the council):

> "A 2018 independent review highlighted 7 specific thematic areas where sustained improvement was required. The thematic review highlighted key failings in the governance arrangements, poor leadership within both commissioning and operational delivery, fragmented services leading to poor patient experience and poor delivery against National standards."

However the analysis of this problem highlights not only significant under-funding, but also flaws which campaigners warned were inherent in the 2012 Health and Social Care Act, which came into force (and established CCGs) in 2013:

> "The current commissioning & operational delivery model is highly fragmented, delivered by multiple commissioners and providers leading to poor system leadership, a lack of appropriate commercial due diligence, and an unstable and unsustainable delivery model resulting in a poor quality & underperforming service."

The solution is effectively to unpick the divisions created by a patchwork of CCGs:

> "The business case proposes to replace the fragmented multiagency approach with a single Lancashire & South Cumbria IPA business unit bringing together the economies of scale of a strategic hub together with 5 place based delivery team. All financial, commercial and operational responsibilities will be delegated to the business unit.
>
> "…The current multiprovider delivery model will be replaced by a single operational management structure"

Among the worst performers

The Business Case goes on to make clear that while IPA performance is "variable", "the region is one of the worst performing in the country against a wide range of indicators."

More of this is explained on page 16, which addresses incomplete referrals (referrals for CHC assessment which have not been assessed within 28 days):

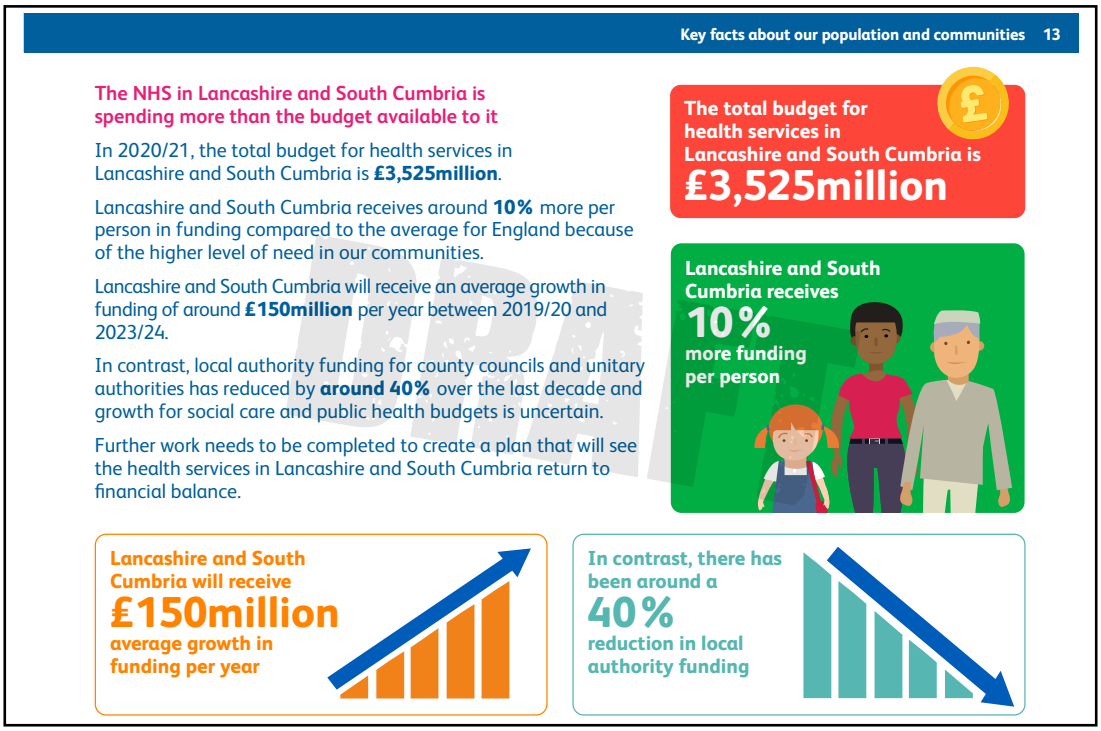
> "For CHC incomplete referrals Healthier Lancashire and South Cumbria is the second worst STP/ICS in the country …. As a system Lancashire and South Cumbria have over 90% of the incomplete referrals in the North of England and almost 56% nationally."

The explanation again underlines the dysfunctional system created by the 2012 legislation which scrapped Primary Care Trusts:

> "In Lancashire and South Cumbria as at January 2020 there are approximately 3,800 reviews outstanding of which over 2,800 are overdue. … The overdue review issue issues date back to 2013 when approximately 2000 overdue reviews were transferred to MLCSU [Midlands & Lancashire Commissioning Support Unit] from Primary Care Trusts without commensurate resource to address." (p17-18)

To make matters worse there are enormous variations across the eight CCGs in numbers of patients deemed eligible for Continuing Health Care and Funded Nursing Care:

> "For standard CHC there is a 150% variance in eligibility rates across the region from the highest to the lowest. Just three CCGs are below the England average. For FNC eligibility there is a 193% variance in eligibility rates across the region from the highest to the lowest. All but two CCGs are below the England average."



Continuing to wield a sledgehammer to crack an exceedingly small nut, the Business Case on page 43 labours the point, explaining the need for this minimal increase in spending to partially remedy the failure of 7 of the 8 CCGs to deliver an adequate service:

> "This business case sets out the rationale for the transformation of IPA across Lancashire and South Cumbria. The case for change and proposed new model of care provides a compelling argument for the proposed changes.
>
> "Approval and mobilisation of the business case will require an additional recurrent investment of £796k from April 2020. This is a pragmatic response to the challenge of both improving and sustaining performance in the next financial years and also moving towards an end to end service."

Partial solution

But £796,000 is only part way to solving the problem, which requires investment of an additional £2-£4 million. This is 1-2% of spending on top of the current £200m IPA budget – but only a microscopic percentage of the £3.5 billion budget of the new ICS.

But rather than spend that small amount to solve the problem, health chiefs have opted to tackle only part of it:

> "Every benchmark the programme has looked at indicates that the service across the rest of Lancashire and South Cumbria is under resourced. **It is also acknowledged that the system does not have an extra £2m to £4m readily available.**
>
> "Consequently, the pragmatic approach suggested to recurrent investment is that in 2020/21 an additional £796k targeted at critical performance improvement and working differently should be made."

The Business Case is therefore revealing. It shows that far from offering bold and innovative moves to address long-standing weaknesses and failures in services for some of the region's most vulnerable people, the new ICS is setting off by agonising over piecemeal and penny-pinching "pragmatic" measures that will leave inequalities in place and subject patients to poor services for years to come.

Far from offering bold and innovative moves to address long-standing weaknesses and failures in services the new ICS is agonising over piecemeal and penny-pinching "pragmatic" measures

NHS overtime deal: no substitute for fairer wages and safe staffing

Martin Shelley -

The World Health Organization (WHO) recently declared 2020 to be the International Year of the Nurse and Midwife, encouraging members of these two professions to expect, not unreasonably, that 'This is our Time' (the strapline of the WHO campaign). In the middle of the ongoing covid-19 pandemic, it's therefore difficult to imagine a better time to reward the contributions of frontline NHS staff in the UK with more generous pay and working conditions.

The current government has certainly put the NHS at the heart of its messaging, as well as its strategy, throughout the pandemic, but is the Tories' enthusiastic – some say cynical – endorsement of state-funded healthcare now reflected in the way it rewards healthcare workers?

Judging from a recent agreement, designed to address the historic injustice of unpaid overtime in the NHS, you could be forgiven for thinking maybe it is. Overtime, paid or otherwise, has become an endemic feature of working in the health service.

Unpaid overtime

A report last year from the independent NHS Pay Review Body acknowledged that the health service had become increasingly reliant on unpaid overtime. And NHS staff surveys bear this out.

Analysis of a 2018 survey revealed that staff were working more than a million hours a week in unpaid overtime, work which has been valued by the TUC at £1.6bn.

Successive surveys in 2015 and 2016 surveys also showed that nearly 75 per cent of staff were working extra hours, and almost 60 per cent were working additional unpaid hours each week – and the latter figure was largely unchanged three years later.

So the new agreement – announced in late May between 15 trade unions and the NHS Staff Council, to ensure staff are paid properly for every hour worked, is a step forward, but the government have stopped short of making the agreement mandatory, offering "guidance" comprising optional, locally negotiated and time-limited provisions, with no mention of backdating any payments.

Those provisions are initially "for the duration of the covid-19 period" only. They still require agreement with local NHS trusts before they are adopted, and "are not intended to replace existing arrangements", say the guidelines.

Commenting on the new agreement, UNISON head of health Sara Gorton said: "Health workers and the public will expect ministers to remember the applause long after the clapping has stopped – and especially when they sit down with unions and employers later in the summer to agree the next NHS pay rise."

The government's approach is an odd one to take at this stage, when the country depends so much on NHS staff.

Much has been made of how it values the work being done by nurses during the pandemic – not least in statements from covid-19-survivors Boris Johnson and Matt Hancock – but funding policies adopted since last year's general election undermine these protestations of support.

Take the issue of nurse bursaries. Scrapped in England back in 2015/16 by George Osborne, and worth up to £16,454 a year, this decision led directly to a sizeable drop in applications from first-time students for nursing degrees and a rising number of unfilled vacancies – currently more than 40,000. Johnson and Hancock may have re-introduced grants for nurses earlier this year, but these are worth no more than £8,000 annually, leaving graduates with debts of up to £60,000 when they qualify.

The NHS has become increasingly reliant on unpaid overtime. And NHS staff surveys bear this out.

Tuition fees

Abolishing tuition fees and wiping out student debt entirely would surely be a more admirable route to show the government's appreciation for the 26,000 students currently on placements to assist frontline healthcare workers.

In April more than 80 MPs signed a letter calling on Matt Hancock to adopt exactly this approach, with a similar appeal following a month later, jointly mounted by the Royal College of Midwives, the Royal College of Nursing, the National Union of Students and the trade union Unison. At the time of writing there has been no response to either of these appeals from the Department of Health & Social Care.

Waiving minor professional fees would be another way to support nurses financially too. Nearly 90,000 people have signed a petition to persuade the Nursing and Midwifery Council to drop its £120 annual registration fee during the pandemic, so far to no avail, and a parallel petition to the Tory-controlled Commons on the matter last month was rejected, despite registration being a statutory requirement.

Onerous fees are, of course, a serious issue that needs to be addressed, but the more pressing question of basic pay in the NHS has been a stumbling block for coalition and Tory-led governments over the past decade. When it comes to public sector pay the Tories certainly have something of a reputation to live down.

Never mind the virtue-signalling 'we're all in this together' displays outside Number 10 on Thursday nights in recent weeks. Who can forget the cheering in the House of Commons back in June 2017 when 313 Tory MPs, including Boris Johnson, voted down an amendment aimed at lifting a cap on public sector pay rises?

Although the Budget later that year ended the pay cap and cleared the way six months later for an increase of 6.5 per cent over the following three years for most NHS staff, inflation in the intervening years has rendered that sum less generous than it first appeared.

At the time the cap was lifted, after years of below-inflation annual rises of 1 per cent, it was estimated that – by 2021, the end of the three-year deal – a band 5 nurse would be less than £2 a week better off, and actually more than £3,000 a year (that's 10 per cent) worse off in real terms than a decade earlier.

Fallen value of pay

Average nurse pay has actually fallen by 7.4 per cent in real terms since 2010, the year the Tory MP George Osborne became chancellor of the exchequer. Yet health secretary Matt Hancock went on national TV in early April this year, at the very height of the pandemic, to tell viewers that "now is not the time to discuss a pay rise for nurses".

Clearly misjudging public opinion, as demonstrated by the results a month later – after more than 65 registered nurses are thought to have died as a result of the pandemic – of a YouGov survey showing 77 per cent of the public support a 10 per cent pay increase for nurses.

Around the same time as the survey was released, Hancock went on social media to reassure nurses "just how valued [they] are", a sentiment undermined somewhat by the near-simultaneous leaking by the Daily Telegraph of a Treasury document suggesting a two-year public sector pay freeze – amid other ideas – to help recoup the £300bn bill for covid-19.

The health secretary's subsequent claim at a press conference the following day – that some nursing staff had already received a "very significant" pay rise of more than 15 per cent – was widely derided in the health sector, and we have yet to see this claim substantiated.

In response, the Royal College of Nursing said, "the majority of nursing staff will not recognise the 15 per cent figure quoted".

Of course cash isn't the only form of remuneration for workers in the NHS.

The provision of adequate safety equipment and staff-to-patient ratios could reasonably be considered part and parcel of any recruitment and salary package, especially in an organisation like the NHS, where more than 245 covid-19-related staff deaths have been recorded so far this year.

Only last week nurses were forced to protest outside Downing Street calling for adequate PPE

Yet several months into the pandemic nurses are still struggling to get personal protective equipment (PPE) good enough for them to do their job properly, and staff shortages persist.

Only last week nurses were forced to protest outside Downing Street calling for adequate PPE, as well as demanding a pay rise to match that recently promised to their counterparts in France for the latter's efforts during the pandemic.

The protest was organised by Nurses United UK, which claimed that Public Health England is "directly responsible for the lowering standard of PPE that NHS staff use daily", restricting most staff to wearing surgical masks and thin gowns when dealing with covid-19 patients, rather than using full gowns and FFP3 respirators recommended by the WHO.

Pressure

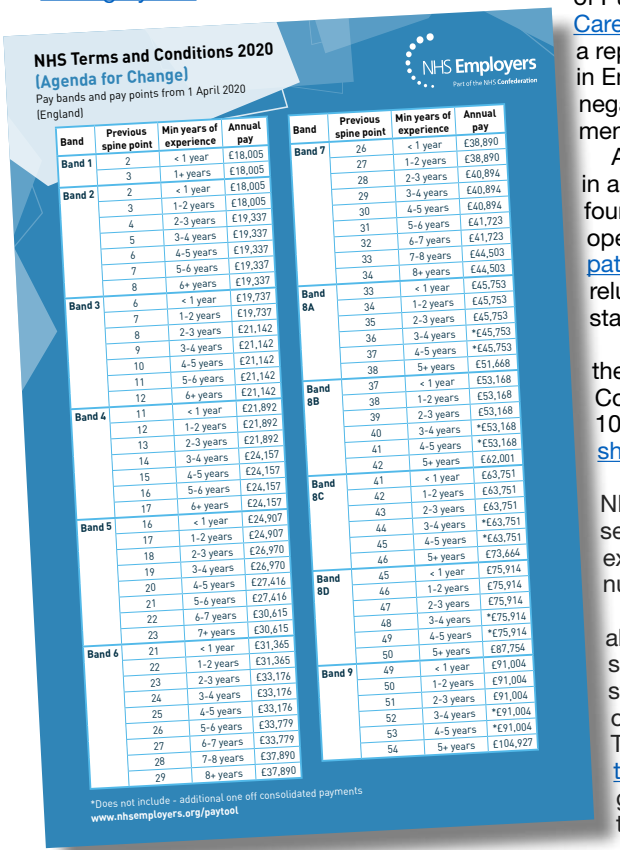
As for staffing, a poll conducted for the Institute of Public Policy Research's Care Fit for Carers earlier this year found that, with a reported 40,000 nursing vacancies in England, increased pressure was negatively affecting the physical and mental wellbeing of healthcare workers.

And last year Southampton University, in a report funded directly by the NHS, found that one in four NHS wards routinely operated with staffing levels that threaten patient safety, and that the government was reluctant to impose mandatory minimum staffing levels to solve the problem.

Later in 2019 came a survey reflecting the same concerns, conducted by the NHS Confederation, showing that nine out of 10 NHS bosses considered ward staffing shortages were endangering patient safety.

This is despite news that the NHS Health Careers website has seen a 220 per cent rise in people expressing an interest in becoming a nurse amid the global pandemic.

If the government really is serious about protecting the NHS – the health service is a central plank of its pandemic strategy, after all – then exploiting that online interest to make good on the Tory election manifesto pledge to recruit thousands of extra nurses would be a good start, and echo the WHO pledge to nurses to make 2020 'their time'.



NHS Terms and Conditions 2020
(Agenda for Change)
Pay bands and pay points from 1 April 2020 (England)

NHS Employers
Part of the NHS Confederation

Band	Previous spine point	Min years of experience	Annual pay
Band 1	2	< 1 year	£18,005
	3	1+ years	£18,005
Band 2	2	< 1 year	£18,005
	3	1-2 years	£18,005
	4	2-3 years	£19,337
	5	3-4 years	£19,337
	6	4-5 years	£19,337
	7	5-6 years	£19,337
	8	6+ years	£19,337
Band 3	6	< 1 year	£19,737
	7	1-2 years	£19,737
	8	2-3 years	£21,142
	9	3-4 years	£21,142
	10	4-5 years	£21,142
	11	5-6 years	£21,142
	12	6+ years	£21,142
Band 4	11	< 1 year	£21,892
	12	1-2 years	£21,892
	13	2-3 years	£21,892
	14	3-4 years	£24,157
	15	4-5 years	£24,157
	16	5-6 years	£24,157
	17	6+ years	£24,157
Band 5	16	< 1 year	£24,907
	17	1-2 years	£24,907
	18	2-3 years	£26,970
	19	3-4 years	£26,970
	20	4-5 years	£27,416
	21	5-6 years	£27,416
	22	6-7 years	£30,615
	23	7+ years	£30,615
Band 6	21	< 1 year	£31,365
	22	1-2 years	£31,365
	23	2-3 years	£33,176
	24	3-4 years	£33,176
	25	4-5 years	£33,176
	26	5-6 years	£33,779
	27	6-7 years	£33,779
	28	7-8 years	£37,890
	29	8+ years	£37,890
Band 7	26	< 1 year	£38,890
	27	1-2 years	£38,890
	28	2-3 years	£40,894
	29	3-4 years	£40,894
	30	4-5 years	£40,894
	31	5-6 years	£41,723
	32	6-7 years	£41,723
	33	7-8 years	£44,503
	34	8+ years	£44,503
Band 8A	33	< 1 year	£45,753
	34	1-2 years	£45,753
	35	2-3 years	£45,753
	36	3-4 years	*£45,753
	37	4-5 years	*£45,753
	38	5+ years	£51,668
Band 8B	37	< 1 year	£53,168
	38	1-2 years	£53,168
	39	2-3 years	£53,168
	40	3-4 years	*£53,168
	41	4-5 years	*£53,168
	42	5+ years	£62,001
Band 8C	41	< 1 year	£63,751
	42	1-2 years	£63,751
	43	2-3 years	£63,751
	44	3-4 years	*£63,751
	45	4-5 years	*£63,751
	46	5+ years	£73,664
Band 8D	45	< 1 year	£75,914
	46	1-2 years	£75,914
	47	2-3 years	£75,914
	48	3-4 years	*£75,914
	49	4-5 years	*£75,914
	50	5+ years	£87,754
Band 9	49	< 1 year	£91,004
	50	1-2 years	£91,004
	51	2-3 years	£91,004
	52	3-4 years	*£91,004
	53	4-5 years	*£91,004
	54	5+ years	£104,927

*Does not include - additional one off consolidated payments
www.nhsemployers.org/paytool

Black lives at risk in unequal NHS

John Lister

Anger at continuing examples of brutal, racist treatment and deaths of black people in police custody has sparked a wave of huge demonstrations not just in the US in response to the killing of George Floyd, but around the world.

In Britain, too, tens of thousands of mainly younger people, black and white, have joined street protests in towns and cities.

Some of these – like the VE Day street parties celebrated by the BBC and right wing press, or the large crowds that have surged to seaside resorts and beauty spots, especially since the Cummings scandal – have ignored or unwittingly breached social distancing rules. One famously tore down the statue of notorious slave trader Edward Colston, and dropped it into the dock from where his trade had operated and caused such suffering.

It's ironic to see that the few scuffles that occurred and the rough treatment of an offensive statue have triggered more concern from ministers than the injustice and discrimination that triggered the events.

Windrush

Empty words of concern from government politicians now can't conceal the deep-seated racism that persists in the continued injustice of the deliberate, institutional, Home Office-led discrimination against the Windrush generation.

Commonwealth and other BAME migrants were essential in the building of the NHS from 1948, with so many people from so many countries coming here to become nurses, doctors, professionals and support staff to deliver the service we all now see as so vital.

The question is surely why opposing racism is even a debate. Why should a minister like Priti Patel, who has herself suffered racial abuse, now be so blind to the discriminatory impact of policies like the now notorious "Hostile Environment" policy brought forward by Theresa May to deter and drive out migrants, and the charges for migrants to access NHS treatment which were first introduced as part of that policy (and which ministers are still committed to increase, even after they were forced to scrap the "immigration health surcharge" for NHS staff).

Last week Medact together with Migrants Organise and the New Economics Foundation published a new study of the impact of these charges as part of the Patients Not Passports campaign. It shows that even during the coronavirus pandemic migrants are deterred from coming forward for healthcare by the government's continuing Hostile Environment.


Daily Mail

YOUR NEXT £1M GOLDEN NURSES ARE INSIDE

As Black Lives Matter protesters topple one statue and deface Churchill memorial — while police stand by — Home Secretary tells the Mail she condemns them as...

LAWLESS & RECKLESS

Pulling down an offensive statue triggered more concern from ministers than the injustice that triggered the events

Passports required

Despite the coronavirus 'exemption' from charging and immigration checks people are still being asked to show their passports for coronavirus treatment, and migrants are still too fearful to seek treatment.

Doctors of the World has revealed that people who are not on the right credit database (including many of the most vulnerable migrants) may find they are refused even a test for Covid-19.

Further evidence of the government's lack of concern to address inequalities and discrimination can be seen in the failure last week of a Public Health England report on disparities in the risk and outcomes of covid-19 to include the views and recommendations of more than 1,000 groups and individuals who responded – or to make any recommendations for further action, despite this being in its terms of reference.

It estimated that 89% of covid-19 infections among healthcare workers may have been caught in hospital, and found that people of BAME background had a higher risk of dying from coronavirus – although none of the first 119 NHS staff deaths from covid-19 worked in ICU.

Poorer access

Surveys by the BMA and RCN have found that BAME doctors and nurses had much poorer access to appropriate and sufficient PPE than white colleagues, and BAME staff are disproportionately represented among lower-graded frontline staff likely to be at greater risk.

Ministers who want to claim to stand for "one nation" politics and want to show concern for racial injustice need to stop criticising protesters and start to take action the inequalities that stare us in the face. First stop doing harm.

Home Office and Equality ministers clearly need to read the recent damning reports from Michael Marmot and UN Rapporteur on poverty and inequality Philip Alston, and act on their recommendations: and Matt Hancock's Department of Health and the NHS need to stop suppressing embarrassing criticism and start developing meaningful policies to address the inequalities that still weaken the NHS and put Black lives at risk.

Breonna Taylor, a 26-year-old African-American emergency medical technician was shot and killed by Louisville police