The lowdown

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

Calls for Javid to stop NHS shakeup

As a beleaguered Matt Hancock finally stepped down, calls are being made for Sajid Javid - the new Secretary of State for Health and Social Care to abandon the sizable NHS reorganisation that Hancock was expected to put before Parliament in the next few days.

Speaking ahead of the Secretary of State's first statement in the Commons, Jonathan Ashworth, Labour's Shadow Health Secretary, said:

"This is not the moment to be rushing into a flawed top-down reorganisation. In recent weeks I've heard increasing worries from NHS and local government leaders that the plans are ill-thought through."

As the Lowdown this week explains, the planned legislation is already proving controversial within Tory circles with arguments raging over boundary changes. The Bill will transfer power back into the hands of the Secretary of State, which has also been questioned by Tory critics. Sajid Javid will want to check this direction of travel before strapping himself in for the bumpy ride this legislation could get through Parliament.

Meanwhile, his intray is already piled high with pressing issues: producing a long-overdue solution on social care, attending to record waiting lists, keeping staff onside after a demoralizing 1% pay offer, rescuing the health and social care from a staffing shortage of 220,000, rebuilding hospitals with repair bills estimated at £9bn plus, and that's without mentioning the continued management of the pandemic.

A crux point will be the autumn spending review and the preceding discussions which must produce a new financial deal for the NHS that is capable of supporting the NHS to meet these huge challenges. Is Javid, a previous supporter of austerity and regarded as a more traditional Conservative willing to make the case?

Paul Evans

A longer version of this article is available online – please visit https://lowdownnhs.info

Also in this issue...

Don't expect a return to normal service any time soon

In his resignation letter to prime minister Boris Johnson last week, former health secretary Matt Hancock said he was "so proud that Britain has avoided the catastrophe of an overwhelmed NHS" and also claimed that "we [now] stand on the brink of a return to normality".

The evidence for the first of those claims is dubious, as several hospitals have just declared alerts due to lack of capacity, and the system as a whole is confronting a record backlog on waiting lists, which commentators suggest could take several years to deal with. NHS patients are therefore unlikely to experience normality any time soon.

'Black alerts' and 'major incident' notices – issued by hospitals when they're dangerously close to reaching 100 per cent occupancy, and the stuff of dramatic headlines each winter over the past decade – have become a year-round rather than a seasonal phenomenon.

Only last week Barnsley Hospital declared it had reached OPEL 4, the 'operational pressures escalation level' that triggers a black alert, following a spike in A&E demand said to be unrelated to covid pressures.

In the same week it became apparent that Derriford Hospital in Plymouth had already been operating under the same alert level for a month, and that Manchester's Royal Infirmary and the North Middlesex Hospital in London had both issued major incident notices.

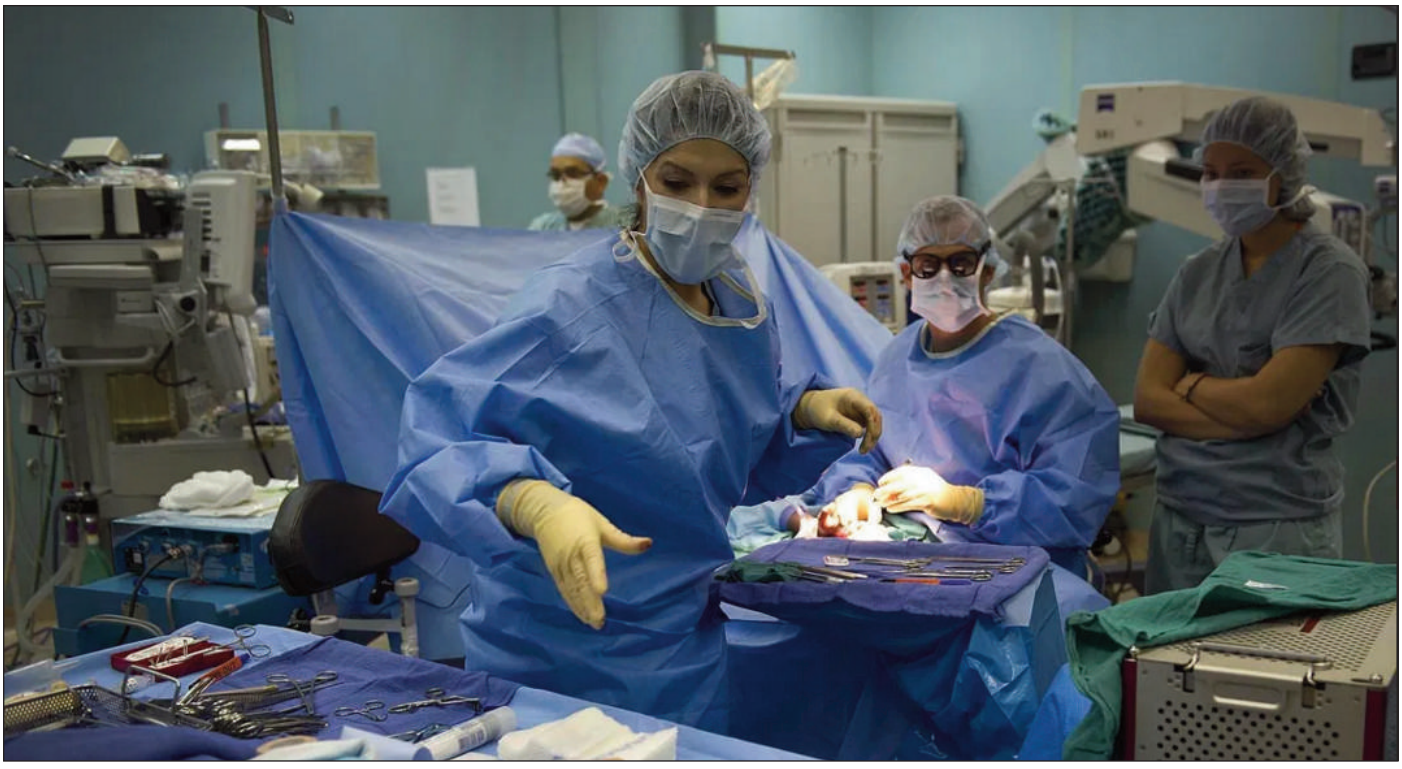
And just two days before Hancock stepped down, the Royal College of Emergency Medicine's (RCEM) vice-president Adrian Boyle warned that current levels of A&E demand were "creating a significant and sustained threat to patient safety".

Within 24 hours came another warning, this time from the Royal College of Paediatrics and Child Health president Camilla Kingdon, who said that emergency departments were overwhelmed with children being admitted, potentially because the support services parents normally rely on weren't available.

Problems predate the pandemic

The pandemic has undoubtedly played a part in the current crisis in emergency and elective care, and the NHS' vaccination programme may well ease this crisis, at least in the short term, although new covid variants and a widely expected third wave could blunt this programme's impact.

A hint of how this might play out came just a few days ago when NHS Providers deputy chief executive Saffron Cordery revealed the number of covid patients in hospital on ventilation beds had



increased by more than 40 per cent over the preceding week.

The crisis in emergency and elective care isn't just a current issue, however. It has been building up for more than a decade, and is the result of government policies based on cuts – which have led to staff shortages, bed shortages and a growing reliance on underfunded community services – and a predisposition for service provision by commercial interests.

Consider the issue of handover delays at A&E, for example. With hospitals facing increased demand from those denied care elsewhere within the NHS during the pandemic, reports emerged earlier this year of ambulance waiting times at hospitals in the South East being almost 40 per cent higher than in 2019, leading to fewer ambulance crews being available to respond to other emergencies.

Yet subsequent research by the Labour Party shows that the number of patients forced to wait with paramedics for at least an hour in ambulances and ward corridors across England leapt by 44 per cent in the 12 months leading up to the pandemic.

Commenting on the situation in April, RCEM vice-president Boyle told the Independent, "We were in a terrible state pre-pandemic… the winter before the pandemic was [already] the worst on record since we started collecting four-hour target performance [statistics]… It wasn't OK beforehand, and there [now] seems to be a normalising of what is abnormal."

An issue of capacity... and funding

Staff shortages remain a historic problem for the NHS too, with an estimated 85,000 vacancies remaining in England from before the pandemic, and a further 112,000 unfilled posts in social care. Earlier this month a report from the House of Commons health and social care committee – presented with evidence from the BMA that thousands of overworked doctors are considering leaving the NHS because of staff burnout – concluded that workforce planning in the health service was driven by limitations in funding rather than by demand or by creating the capacity to service that demand.

Similar recruitment issues are also impacting primary care, with GPonline recently reporting that there are now 10 per cent fewer GPs per patient compared to five years ago.

Bed shortages, however, lay at the heart of the NHS' capacity problems, potentially explained away by the strategic reduction in the number of beds (almost 10,000) available for elective surgery last year to accommodate the needs of covid patients.

But the number of beds was already at an all-time low in the months leading up to the pandemic, with more than 17,000 having been cut from the health service's stock of almost 145,000 that was available in 2010, when the Tory-dominated coalition government initiated a nine-year funding squeeze.

And a report by the BMA illustrates how, in spring 2019, hospitals' 'core bed stock' was no longer sufficient to deal with the level of year-round demand on the NHS, leading more than 90 per cent of frontline doctors to agree that the health service was already "in a state of year-round crisis". The report highlighted the use of extra 'escalation beds', normally deployed only in winter months, well into the spring that year, when 83 per cent of hospital trusts were still using them.

Meanwhile, a Nuffield Trust study conducted before the pandemic took hold found that long-term under-investment had already placed the UK firmly near the bottom of a 31-country league table for health resources. It came in 29th for its stock of hospital beds – with only 2.5 beds per 1,000 people, compared to 8 per 1,000 in Germany.

Paltry response

In March this year, NHS Providers released similar figures, this time for critical care capacity, showing the UK has 7.3 critical care beds per 100,000 people, compared to Germany's 33.8 and the US' 34.3 beds.

These statistics help explain why, earlier this month, there were more than 5m people waiting for hospital treatment in England – the highest figure since 2007 – and why the fact that 50,637 fewer people had waited more than 52 weeks (still leaving a total of 385,490) is not that impressive, given that just 3,097 patients had faced such a long delay a year earlier.

Leaked estimates from the Cabinet Office suggest it would cost up to £40bn to clear the waiting list backlog. The latest initiative from the government to tackle the problem, however, represents a national spend of just £160m to fund 'accelerator sites', a paltry sum compared to the £10bn offered to private hospitals last year under a 'framework contract' to take on NHS waiting list patients.

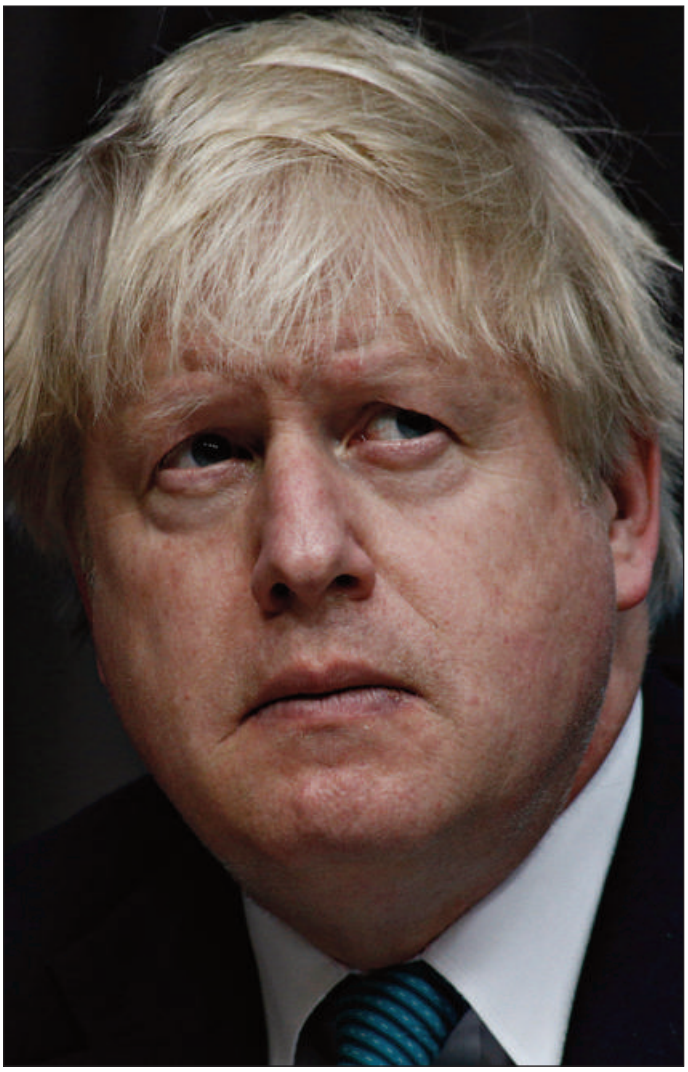
The 'accelerator systems programme' will distribute these slim pickings across 12 areas and five specialist children's hospitals, with £11.3m going to the NHS Devon Clinical Commissioning Group to pay for three initiatives specifically aiming to reduce waiting times for certain types of operation.

At the time of writing it's unclear what we can expect from Hancock's successor as health secretary, Sajid Javid. But it's interesting to note that his second statement to the media, on the day of his appointment, omitted the words, "My most immediate priority [will be] to see that we can return to normal as soon and as quickly as possible" which appeared in his first statement.

In the absence of any such normality, maybe we should just follow the reality outlined above by the RCEM's Adrian Boyle, and simply accept that the abnormal has now been normalised.

Martin Shelley

Tory splits on Health Bill could be campaigners' opportunity



Matt Hancock's resignation and replacement by austerity man and neoliberal Sajid Javid could well result in further delays to the government's Health and Care Bill giving statutory powers to Integrated Care Systems (ICSs). Although no date had been announced for publication of the Bill, it had been expected that the first and second readings would take place prior to the summer recess on July 22to the summer recess on July 22.

But even with NHS England primed and cocked ready for the new legislation to take effect next April, it's not at all clear whether Javid will want to walk straight in to the battles that were lining up over aspects of the Bill that Hancock had specifically added to the NHS England proposals, giving him new powers.

Tensions and questions over the wisdom of the Bill had been growing within the Tory Party. Analysis for i-news by Spectator assistant editor Isabel Hardman, written before news broke of Hancock's affair with Gina Coladangelo, suggested he had lost the confidence of back benchers and ministerial colleagues, and that following Prime Minister Johnson's famous leaked description of him as "f****** hopeless":

"I understand from multiple sources that Number 10 is not fully on board with the reforms as they currently stand."

More evidence of Johnson's lack of confidence in Hancock could be seen in the continued expansion of a separate Downing Street "delivery unit" to "oversee" the recovery of the NHS after the pandemic, and "intervene where delivery is slowing". The HSJ has highlighted the advertisement for a deputy director to join the growing team based in the Cabinet Office, which already includes former NHS hospital and Centene boss Samantha Jones and former McKinsey man and NHS Improvement director Adrian Masters.

Contentious elements

Hardman points out that 20 percent of the Bill is "politically driven" and had been inserted by Hancock over and above the changes requested by NHS England.

On at least one of these additional points Hancock had already had to retreat, with the HSJ reporting that the Bill would not axe the Independent Reconfiguration Panel, as proposed in the White Paper. It would be logical for this retreat also to extend to dropping plans to end the right of local authorities to block controversial reconfigurations and closures and refer plans to the Secretary of State – although it was not clear whether this White Paper proposal would remain in the Bill.

The most contentious elements of the likely Bill include new powers for the Secretary of State to intervene in controversial local reconfigurations, abolish arm's length bodies and (without restoring the duty of the Secretary of State to provide comprehensive health services, axed by Andrew Lansley's 2012 Act) give orders to NHS England.

Hardman reports: "Backbenchers aren't happy. They already don't trust Hancock with the powers he has. 'Do I want the Secretary of State to have even more power? What do you think?' laughs one, bitterly."

Contentious issues also include the potentially disruptive requirement, spelled out in February's White Paper, for ICS boundaries to be coterminous with top-tier local authorities.

This issue also put Hancock at odds with NHS employer bodies, NHS Providers and the NHS Confederation, both of which

have (belatedly) cottoned on to the implications of the February proposals, which would require a reorganisation of several ICSs which largely follow the arbitrary boundaries of the 'Sustainability and Transformation Plans' established by NHS England five years ago.

Essex for example, replete with Tory councillors and MPs, was divided into THREE STPs – with West Essex hived off to link up with Hertfordshire, and North East Essex tacked on to Suffolk, leaving a core STP covering Mid and South Essex. This division followed on the exclusion of West Essex and NE Essex from the "success regime" set up in 2015 to address chronic failures of leadership in Essex – ignoring loud protests from local councillors at the time.

Setting boundaries

Now Essex County Council's new Tory leader Kevin Bentley has revived the call for a single county Essex ICS, in line with Hancock's White Paper, but in opposition to local and national NHS bosses, with NHS Providers boss Chris Hopson arguing that boundary rows could "worsen patient care".

Other ICS areas facing potential boundary rows involving local Tory politicians include Frimley (spanning parts of Surrey, Berkshire and Hampshire), Birmingham (divided into two ICSs) South Yorkshire and Bassetlaw, Derbyshire, and Cumbria.

Will Javid simply follow Hancock's line and walk straight into a series of arguments?

There are other concerns about the plans. The NHS Confederation's spokesperson on ICSs Dame Gill Morgan has warned that the proposals could bog down NHS bosses in interminable meetings, telling the HSJ: "… particularly if you're in a big ICS, that could be an absolute panoply of meetings and subcommittees, all of which are valuable in governance terms but in delivering the vision of partners … to deliver long term health [solutions] it could be a bureaucratic nightmare."

To make matters worse, it's clear that many of the meetings required by the new system would be largely tokenistic and pointless. This is illustrated by recent decisions in Greater Manchester, where it appears that one of the largest ICSs is set to ignore the niceties of "place" (borough) level structures and allocate the lion's share of the budget for acute care to the "provider collaborative" of large acute trusts with a combined budget of £4.8 billion.

Only the much more limited stream of funding for primary and community services would be devolved to borough-level boards.

Guidance too vague

In other words this vindicates the warnings of campaigners that the forced merger of Clinical Commissioning Groups and the carving of England's NHS into just 42 ICSs would end any local accountability. The Greater Manchester version of "integration" of health care completely removes any local voice or control, and drags the NHS back to the old days when the large acute hospitals – now banded together in an even more powerful block – called all the shots.

Meanwhile new guidance from NHS England on the design framework for ICSs helps identify issues on which campaigners and opposition MPs might usefully focus and propose amendments to the Bill to draw the teeth of the new bodies.

Minimal, vague reference to the role of the private ("independent") sector is coupled with repeated vague references to "other partners" to be involved in decision making committees – at a time when we know Virgin has already been given a seat on the board of the Bath Swindon and Wiltshire ICS. The Bill must be amended to specifically exclude any involvement in any decision-making ICS bodies of companies providing clinical, support services, data services or consultancy to the NHS: they should be referred to as contractors rather than misleadingly termed "partners".

Numerous references in the White Paper and ICS websites to creating an "agile" and "flexible" workforce across ICS areas underline the need – especially at a time of chronic staff shortages and rock-bottom post-Covid morale – for ICSs to be required to comply with nationally-agreed pay, terms and conditions, and negotiate terms for any local "flexibility" with the trade unions.

Bringing commerce on board?

The ICS NHS body is required to include a member "drawn from general practice providers": this vague phrase could include a representative of Centene or other commercial companies holding GP contracts. The Bill must be amended to exclude all but GPs employed on the main NHS (GPMS) contract. And in line with the professed aim of "integrating" primary care and other NHS services, ICSs as commissioners of GP services should be banned from issuing any more of the APMS contracts through which Centene and similar corporations gained their foothold in primary care.

The new guidance weakly "invites systems to consider" agreeing arrangements for transparency and local accountability "including meeting in public with minutes and papers available online": the Bill clearly needs to be amended to require ICSs to operate this way, but also to require that all ICS business and contracts must be discussed in public with none of it deemed commercial or confidential.

The Lowdown will offer a more detailed critique of the Bill, its implications, and more extensive suggestions on how its damaging proposals can best be combated as soon as it is published. But don't hold your breath waiting!

John Lister

NICE: deciding what the NHS provides... and how

The National Institute for Health and Care Excellence or NICE was set up in 1999 and is perhaps best known to the public for two areas – clinical guidelines on the most appropriate treatment and care for specific conditions, and guidance on whether treatments/procedures/diagnostics can be used by the NHS based on clinical and cost-effectiveness. The latter area covers what are known as Technology Appraisal Guidance, Highly Specialised Technologies Guidance, Diagnostics Guidance, and Medical Technologies Guidance.

The organisation tends to receive media attention when a new and very expensive drug or treatment has received approval in the UK, but there is doubt over whether it will be made available on the NHS.

From the outset its aim was to create guidelines on the use of treatments by the NHS across the UK and so reduce the rationing of treatment by postcode that had become commonplace.

In the ensuing decades, NICE's responsibilities expanded considerably and it now has a much larger remit covering the NHS, public health and social care (see box). NICE produces a vast range of publications, including guidance, which includes clinical guidelines, quality standards, advice (a critical assessment and summary of latest evidence), evidence summaries, and medical technology briefings.

The development of clinical guidelines

NICE clinical guidelines advise the most appropriate treatment and care for people with a particular condition. They cover many topics, with most being about a specific illness or condition, such as dementia or breast cancer. Other guidelines focus on broad types of care, such as maternity services, or cover more general topics or symptoms.

There is a set process for the development of clinical guidelines *(see box on right)*.

Included in the development of a clinical guideline is an assessment of the cost-effectiveness of an intervention, service or programme. Cost-effectiveness is the balance between the estimated costs of the interventions or services and their expected benefits compared with an alternative.

Clinical guidelines normally take months to develop and publish, but in the case of Covid-19, NICE began work as soon as the pandemic was identified and by June 2021 had already published 18 guidances covering Covid-19 treatment in a range of patients, and related issues, and published 11 lots of NICE advice, on a range of subjects.

Technology appraisals

The other area most often in the media is NICE's technology appraisals, covering drugs, diagnostics, procedures and medical technologies (e.g., drug delivery technology, stents, etc.)

One of the reasons NICE was set up was to enable patients across the UK to receive costly drugs and technologies. Prior to NICE, drugs were approved and whether they got prescribed was based on whether the NHS in your area could afford them – a postcode lottery of prescribing. If the NHS refused to prescribe due to cost, this often led to lobbying by charities and the pharmaceutical industry including via emotive media stories.

The advent of NICE took all these issues away from individual NHS organisations. In addition, for very expensive drugs it has opened up a way for the NHS to prescribe these by triggering negotiations on price and usage between NHS England and companies based on data rather than emotive media stories.

NICE's decisions are based on clinical data and a figure known as a Quality of Adjusted Life Year (QALY) which together are used to compare new drugs to ones already on the market and assess whether a new drug gives value for money.

This calculation can be made for a wide variety of treatments and procedures – ones that improve quality of life, like a treat-

AREAS OF WORK:

- **Clinical guidelines – recommendations for the NHS about the treatment and care of people with specific conditions**
- **Health technology guidance – recommendations for the NHS on new and existing medicines, diagnostic techniques, treatments and procedures**
- **Public health guidance – recommendations for local authorities and others on promoting and maintaining good health and preventing disease**
- **Social care guidance – recommendations for local authorities and service providers about care for people using social care services**
- **Developing quality standards for the NHS, local authorities and other providers of health and social care services in England**

ment for eye disease, and for those that extend someone's life, such as a cancer treatment.

For each drug/treatment a cost is calculated per QALY. Generally, the more it costs to achieve one QALY, the less likely NICE will recommend use by the NHS. If the cost to achieve one QALY is high, companies need to have a much better argument for approval. The threshold is not set in stone, but in practice if a treatment costs less than £20,000 per QALY it is likely to be considered cost-effective.

If a treatment costs between £20,000 and £30,000 then more questions will be asked – how the quality of life issues have been measured, does it offer other benefits, etc. For example, a treatment that means fewer clinic visits would lead to a benefit of increased clinic capacity. There are also social value judgments that are important considerations, for example there is always strong public support for treatments that save a child's life.

The calculation of QALY is fed into the technology appraisals. NICE carries out a cost comparison case, using a QALY figure, to determine if the new drug shows that it is likely to provide similar or greater health benefits at a similar or lower cost than drugs already recommended in the guidance for the same condition.

There are three types of technology appraisal: the single technology appraisal, which assesses a single drug or treatment, usually one that is new or seeking an extension to its use; the multiple technology appraisal that assesses several drugs or treatments used for one condition; and the fast track appraisal.

For new drugs, the process of appraisal starts before approval of the drug, which enables NICE to produce guidance soon after the technology is introduced in the UK.

The fast-track appraisal (introduced in 2017) is used for drugs that offer exceptional value for money. The process aims to make the drug available to patients 30 days after the drug has been approved by NICE. This applies to drugs costing up to £10,000 per QALY.

For very expensive drugs – those that have a net budget impact of £20m or more per year in any of the first three years of its use in the NHS – NICE's calculations trigger a commercial discussion between NHS England and the company.

The discussion will try to come to some arrangement to make the drug available to NHS patients, and may involve different models for how the NHS might pay for the product.

There are special arrangements for treatments for very rare conditions. They are evaluated against a sliding scale, so that the more additional QALYs a treatment offers, the more generous the cost per QALY level it will need to meet, starting at £100,000 per QALY, rising to a maximum of £300,000 per QALY.

NICE's work allows patients access to extremely expensive life-saving products as soon as it is feasible.

This was the case for Novartis Gene Therapies Zolgensma approved in March 2021, which costs £1.79 million for a single dose. It is used to treat babies and young children with the rare and often fatal degenerative disorder of progressive spinal muscular atrophy (SMA).

The approval was based on draft guidance from NICE, which includes a managed access arrangement, while further data is collected.

NICE notes that despite the high cost of the treatment, it can be recommended for use on the NHS because of the evidence of exceptional benefit to young babies, potentially allowing them to reach normal childhood developmental milestones.

Although the headline figure is £1.79 million per dose, this is not the price the NHS will be paying. The developers of Zolgensma and NHS England negotiated a discounted price after confidential negotiations.

For anyone working in the NHS, public health and social care, the work of NICE is now ever present – from guidance on antibiotic prescribing to guidance for supporting adult carers.

Sylvia Davidson

NHS reorganisation – a never-ending story

For the first 26 years of its life after it was launched on July 5 1948 the NHS was hardly changed in structure. But since 1974 a regular churn of reorganisations and structural adjustments has consumed huge amounts of management time and energy, often with highly questionable results. Numbers of relatively local bodies running the NHS have up to now varied from over 700 to as few as 80.

By any measure the current proposals, expected to be spelled out in a Health and Care Bill before Parliament's summer recess, will reduce England's NHS to the lowest ever number of 'local' bodies, with no more than 42 Integrated Care Systems (ICSs) – and the possibility that some of these may merge.

Now, as campaigners nervously await the new Parliamentary Bill to legislate for this latest major reorganisation – and while the vast majority of the wider public remains blissfully unaware that anything is happening – it's worth noting how the coming changes compare with those that have gone before.

In 1948, when the NHS in England and Wales was run jointly, there were 377 hospital management committees, and 36 teaching hospitals with their own board of governors, while health centres, ambulance services and other community services were run by 146 local authorities, and general practices, NHS dentistry, pharmacists and opticians were run by 140 executive councils.

The 1973 NHS Reorganisation Act was drawn up by Ted

Heath's Tory government and implemented by Harold Wilson's Labour government.

It brought the first real focus on more local accountability and involvement of the public in the decisions on health care, and established a 3-tier system of Regional, 90 Area and 205 District Health Authorities (reducing to 199 by 1979). It also integrated ambulance services, and some community services, previously run by local government, into the NHS for the first time. Primary Care was to be run and financed separately through Family Practitioner Committees.

Concern over local accountability had been increased by the succession of controversial hospital mergers and closures linked to the building programme flowing from the 1962 Hospital Plan for England and Wales. In the stormy years that followed local concerns were to be increased by financial pressures forcing cutbacks in local services.

Binding cash limits

This pressure escalated from 1976 when a monetary crisis had forced Harold Wilson's Labour government to seek support from the International Monetary Fund: one of the strings attached obliged ministers to cap NHS spending at local level. As a result hospital and mental health services (but not primary care) were to be subjected to formal "cash limits," and Margaret Thatcher's Tory government made these cash limits legally binding in 1980.

The next reorganisation followed in 1982, in which the Area Health Authorities were abolished, and district health authorities were restructured: shortly after this (1983) it was the 190 District Health Authorities that were tasked with putting non-clinical hospital support services out to competitive tender.

The following year saw the restructuring of NHS management along "business" principles as proposed by Sainsbury boss Roy Griffiths in a report for the Thatcher government. Out went consensus management and administrators, in came higher-paid general managers, soon rebranded as chief executives, and executive directors on short term contracts.

Also in 1983 Chancellor Nigel Lawson imposed hefty cuts in NHS spending, resulting in a wave of hospital closures and a rapidly worsening performance as waiting lists grew.

By 1987 the years of frozen or falling funding had forced widespread closures of beds and cuts in services, and – after Thatcher's third election win in the summer – resulted in increasingly critical headlines in Tory newspapers complaining of waiting lists at crisis point and patients dying waiting for cancer and heart treatment.

This triggered a limited increase in spending – and a secretive "review" of the NHS by a hand-picked team of advisors, whose plans surfaced as the NHS and Community Care Act in 1990.

The Act, strongly opposed by the BMA and in parliament, split the NHS for the first time into purchasers (District Health Authorities, with cash-limited budgets based on local population, and 306 "GP Fundholders", with their own budgets to "shop around" and purchase elective treatment for their patients) and providers (NHS Trusts, of which 57 were established in 1991, followed by several waves eventually creating 270, each with their boards). The Act also abolished Family Practitioner Committees and replaced them with Family Health Services Authorities (FHSAs).

The providers were required to compete with each other for contracts (and funding) from DHAs and GP Fundholders. The more complex system required tens of thousands more managers and administrative staff – but was still drastically under-funded.

The Act also included plans set out in another Griffiths Report in 1988, to remove long term care of the elderly from the NHS – where it was free at point of use – and switch it to social services, where it would be subject to means tested charges.

The Act slashed the number of DHAs from 190 to 145 by 1993, with plans to further reduce to 108 by April 1994 and eventually to as few as 80-90, raising questions over lost local accountability.

Five years later the Health Services Act reorganised the 14 regional health authorities into 8 – and scrapped the FHSAs that had just been established.

Tony Blair's victory in 1997 was followed by a new policy statement "The New NHS, Modern, Dependable," – but no new money. GP Fundholding, which had left a minority of GP practices holding substantial unspent funds, was scrapped in 1998, in place of which 481 Primary Care Groups were established as advisory bodies to District Health Authorities.

In 1999 the devolution of power to Scotland and Wales meant that the structures of the NHS increasingly began to diverge as both devolved administrations took their chance to progressively roll back the 'internal market' and reinstate the integrated model of the pre-1991 NHS.

'Any willing provider'

In England from 2000 Primary Care Trusts (PCTs) began to be established, with up to 300 eventually agreed. As PCTs developed they replaced DHAs as hybrid bodies, commissioning local services, while also providing community health services.

New Labour's NHS Plan also brought in the cash-limiting of GP services which had until that point been the only sector of the NHS not subject to spending constraints.

In 2002 28 Strategic Health Authorities were established, but 4 years later these were reduced back to 9, and numbers of PCTs were halved to 151 as a result of the controversial "Commissioning a Patient Led NHS" reorganisation which deepened the pur-

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chaser-provider split. It required PCTs to separate themselves from community services and contract them out, inviting tenders from "any willing provider" – until Andy Burnham as Health Secretary stepped in in 2009 and, under pressure from the unions, and triggering fury in the private sector, brought a temporary halt to the privatisation by insisting that NHS trusts should be the 'preferred provider'.

A year later the Cameron coalition took office and immediately launched into the biggest-ever top-down reorganisation of the NHS

The last remaining community services were finally split from PCTs in 2011, in the midst of Health Secretary Andrew Lansley's disastrous market-based reorganisation, which scrapped both PCTs and the remaining SHAs, and established 207 Clinical Commissioning Groups (CCGs) with no regional coordination, headed by NHS England. Regulations required the CCGs to put an increasing range of clinical services out to competitive tender.

The Health and Social Care Act was eventually implemented from April 2013 – but it was just over a year later that Simon Stevens, one of the movers of New Labour's marketising "reforms" from 2000, was appointed CEO of NHS England.

Toxic terminology

He swiftly published the Five Year Forward View, which barely mentioned competition, and which first introduced the notion of Accountable Care Organisations (ACOs) to the lexicon of British health care reorganisation, coyly referencing its origins in the chaotic US health care system.

Stevens, who has never explicitly mentioned his prior role (while a leading executive in the giant US insurance corporation UnitedHealth) in leading discussions promoting concepts of "accountable" and "integrated" care at the World Economic Forum in 2012, eventually recognised that the terminology had become toxic, and NHS England began to rebrand ACOs as "Integrated Care".

However ACOs were still in evidence when, at the very end of 2015, the emphasis switched from the Five Year Forward View to the establishment of "Sustainability and Transformation Plans," which were to be drawn up across 'local health economies' at breakneck pace behind closed doors by NHS chiefs, where possible with token involvement of local government.

During 2016 England's NHS was carved up into 44 STP areas, each of which set up extra-legal bodies to drive the implementation of plans that not only lacked any popular or political support, but which in several cases proved completely impractical.

Nonetheless the STP 'footprint' areas, with some adjustment in the north of England, have become the 42 areas now to be redesignated as Integrated Care Systems, with no real clarity over the extent to which the previous CCG areas ("places") will continue to have any voice over policies decided by the most remote-ever "local" management bodies.

One obvious conclusion from this constant churn and redisorganisation is that there is no past golden age to which we can neatly restore the NHS. The period prior to 1974 gave little or no voice to local communities, with the NHS still not including ambulance or community services, and with primary care very much separately controlled. But as services have since been brought together, the competitive market has also split them up into contracts and brought rivalries rather than collaboration between NHS providers.

Changes have experimented with both many small (Primary Care Groups) and fewer large 'local' bodies (Area Health Authorities), and with health authorities, PCTs and CCGs of various sizes and composition – but none of these bodies have been elected, and none have adequately engaged with or won the confidence of local people.

To make matters worse, the underlying constraints on resources have limited options – with cash limits for the last 45 years that extended to cover all sectors of the NHS.

The fact is that while some damaging cuts and ill-conceived plans have been forced through, numerous attempts to force local NHS leaders to uphold cash limits and balanced budgets above delivering health care to those who need it most have proved unsuccessful. Most hospital management have proved themselves more willing to take their chances with rising deficits than to endure the hostile press coverage and public anger that would flow from turning patients away.

This has continued to this day – only last spring NHS England stepped in to convert £13.4 billion of accumulated trust borrowing to cover deficits into long-term Public Dividend Capital, recognising that it could never be paid off.

Time and again services have been saved or cuts and reconfiguration deferred or scaled back as a result of strong, focused local campaigns, sometimes backed by local newspapers, courageous local councils and MPs, and often supported by health unions and the wider trade union movement.

A common cause

That's why, for all the damage it has done, the Lansley Act has not resulted in the end or wholesale privatisation of the NHS, as some had feared. The reservoir of public support for the NHS at local level is still a major political constraint on senior NHS management and ministers at local and national level – and will also limit the extent to which ICSs can be used as local levers to force through cuts in spending and restrictions on access to services.

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Awkward questions linger over Leicester plan

Leicestershire's highly secretive NHS leaders have been at it again. A scheduled 2-hour meeting on June 8 to nod through a 147-page Decision Making Business Case (DMBC) to kick start their plans for reconfiguration and new hospital buildings included an hour for questions from the public – not one of which was answered, despite the session dragging on for almost FIVE hours.

Nor were long drawn-out proceedings any indication of rigorous scrutiny of the flawed Business Case – not a single member of any of the three CCGs present had a single objection or critical word to say. Only one non-executive member subsequently privately confessed to having not read the document – but others were doubtless happy to keep their ignorance of the DMBC to themselves.

The DMBC had been in the hands of CCG members for weeks, but was shamefully only issued to the public after the meeting had started, for fear that somebody might be able point to its weaknesses and disrupt the carefully choreographed PR effort to promote the £450m-plus project through a docile local news media.

Evading scrutiny

The joint meeting of CCGs covering Leicester, Leicestershire and Rutland was also supposed to take note of a 760-page document analysing the public response to the consultation – which had only been released publicly on May 26 – having been kept under wraps for two months.

This latest effort to suppress any public scrutiny of plans was challenged by Save Our NHS Leicestershire and publicly criticised by Patrick Kitterick, chair of the joint scrutiny committee in Leicester and Leicestershire, who warned (in vain) that "To rush to a decision without the proper opportunity for public scrutiny is a mistake which I would urge the Board Meeting to avoid."

One obvious reason for the reticence in releasing this document is that it exposes the failure of the project leaders to change almost any aspect of the proposals in response to the views expressed by the local public in the consultation.

One exception is the welcome decision to fund a minimum 3-year trial of the Freestanding Midwife Unit rather than the inadequate proposal of a 1-year trial. The extended trial had been demanded by campaigners and Leicester City Council's Scrutiny Committee, and the need to retain the Unit, currently provided in Melton Mowbray, was raised by the largest number of public comments on the consultation.

Query over final cost

However the DMBC leaves nagging doubts as to how the unit is to be funded, or indeed if it will be built at all.

The consultation left other serious questions unanswered, not least on the likely final cost of the plan as a result of Covid and its aftermath, changes in government and NHS policy on a number of issues, and the belated decision to plan bed numbers through to 2032 rather than the ridiculously short time

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The stress on involvement of local government, links with social care, and even efforts to press gang council leaders into supporting NHS initiatives have markedly increased since 2015, with STPs and subsequent moves towards ICSs – but the extent to which councils have any resources to offer or any political influence has been drastically reduced by a decade of brutal cuts that have more than halved local authority budgets.

As we prepare to fight the warped Tory vision of "integrated care" it is obvious that we need a coherent alternative view of what we would like to see: however there is currently no common approach – and it's clear that some campaigners will focus solely on opposing the coming Bill rather than seeking to mobilise the necessary political movement pressing to remove or blunt its offensive elements through amendments.

One common factor is all of us would much prefer not to be starting from here – an NHS disintegrated and fragmented by over 30 years of marketising 'reforms', crumbling after a decade of frozen funding and inadequate capital investment, wracked by chronic staff shortages, and its senior management largely lobotomised by decades of increased dependence on management consultants and their various quack theories that divert money and effort from patient care.

As the government faces internal wrangles over the scope and shape of the Bill, the challenge is for campaigners to find enough common cause to exploit these divisions and combine once more to defend the NHS against a major threat.

John Lister

...continued from page 11 (Leicester plan)

frame to 2024 – by which time the new hospital will not have been completed. Project leaders now admit that to preserve the existing provision of 2.4 acute beds per 1,000 population the Trust will need at least 300 and as many as 800 additional beds on top of the DMBC proposals.

These have not been costed.

Nor have the changes required to adapt hospital wards and clinical areas to post-Covid infection control. The DMBC concedes that "because of the uncertainty … it is not currently possible to assess the impact on the capital costs." So the CCGs signed off a pig in a poke.

Extra cash needed

It's clear to all that the £453m funding that has been promised by the government and from charitable funding will not be enough to complete the project – but far from clear how much extra, if any, can be obtained from the government.

To make matters worse the current plan will also drain the Trust of capital funding, leaving a £33m bill for chronic backlog maintenance. If no extra cash comes from the government parts of the project will need to be scaled back or axed – with the most likely first casualty being the Midwifery Unit. No wonder they were so keen to keep the plan under wraps.

The next challenge for project leaders is to produce an Outline Business Case – for which these awkward questions need to be answered.

The campaign goes on: it's not over till it's over! ***JL***

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