Keep our NHS public

KONP Briefing

December 2020

KONP fights for Local Test and Trace (continued)

Oxfordshire is one of the 150 local authorities to provide an add-on service when Serco's "NHS" service fails to reach a Covid sufferer within 24 hours. These do work. They rely on local information, local contacters, local phone numbers. Workers will even go to a person's house if this is the only way to communicate. And when they do communicate, they can offer practical and financial support and a listening ear. But this local add on is not enough. We need a scheme which is totally under local control from start to finish. We are keeping up the pressure for this in collaboration with WeOwnIt.

The Oxfordshire scheme has been going for six weeks and is working already much better than the national one. When it was introduced to JHOSC at their November meeting, one of the committee, with a lifetime of work in the local NHS behind her, said it was the best example of co-ordination between agencies she had ever seen. The chair calculated that, leaving aside the students in the 800 cases the Director of Public Health had received this month, workers had been successful in 82 per cent of the contacts which the national scheme sent them. You can read the County Council's press release about the scheme here.

JHOSC was addressed by Janet Phillips, on behalf of KONP and WeOwnIt, on the urgent need for a truly local Find, Trace, Test, Isolate and Support system for Oxfordshire. Janet reminded the committee of the wasted billions - £22Billion poured into the likes of SERCO – and invited the committee to think how even a fraction of that would have allowed our public services to get on top of this virus. Our public sector workers have shown they are more than qualified for the task.

Janet went on to address the full City Council on the issue the following Monday. The City passed a cross party motion to work towards local test and trace at that meeting. Other Oxfordshire Councils are considering how to follow suit. The

motion (16a), which can be downloaded here, has since been copied by campaigners across the UK.

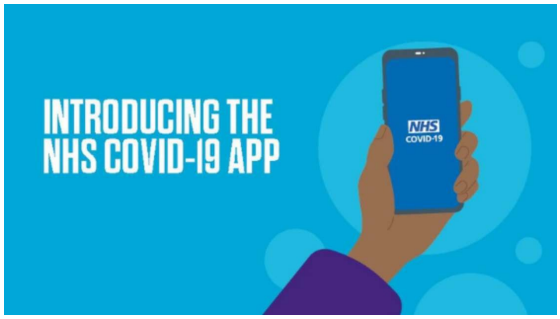
Rampant privatization not the answer to Covid

Almost a year since the first whispers of the pandemic reached us from China, where people suffered the first wave, we in the UK are coming out of a second lock down. Since the beginning, the government has used special emergency legislation to make this one of the biggest private health bonanzas on record. Taking over the commissioning role from local CCGs, and keeping tight national control of proceedings, the government have spent a bonanza of taxpayers' money on private sector contracts.

These contracts have been made without the usual due process, and many with companies that have no track record of health at all, companies which then sub or sub-sub contract to firms that do. Covid-19 has provided cover for an immense shift away from NHS services to a chaotic market place. This has been marked by failure after failure, and each failure leads to more Covid-19 deaths and even more long-term Covid-19 ill health.

Nowhere is this more obvious than in the flimsy, failing, national track-and-trace system. This could be best described as some Heath-Robinson contraption being built as it drives along – except in this case it fails to drive. There is a system for finding – people ring in with symptoms to get a test. The tests happen, run by lots of companies, and swabs are sent to private labs which don't work that efficiently. Then the ringing up begins, using call centre techniques, where the callers have no experience of dealing with people in a possible health crisis but who have received a few hours training. And all of this is, at best, 50 per cent effective.

Alongside this, and entirely separately, an app has been developed by Google and Apple for the UK which bleeps red on your smart phone with a message to self isolate if you are near someone with Covid-19. No phone call, no follow up – just a message to go home and stay there for fourteen days. No wonder this has failed.



Privatisation is being ramped up in other ways too. Private hospitals have had their own bonanza. Not only has the demand for private hospital services continued to climb during the pandemic, as waiting lists in the NHS continue to lengthen and rationing continues to bite, but only two thirds of the treatments that the government bought from private hospitals have been used.

Clinical Commissioning Groups abolished by 2022

At present, Oxfordshire's Clinical Commissioning Group manages the healthcare needs of the local population of around 700,000 people. It has direct links with the County Council's Health Overview and Scrutiny Committee (HOSC) and is formally responsible to local GPs. It certainly has many problems, among them chronic underfunding and a legal requirement to put health services out to competition on the private health market. But its location and the link with the local authority means there is some element of local accountability and at least the possibility of local input into decision making. We saw that at work in the PET CT Scanner story in 2019.

All of that is about to change dramatically. By 2022, all 130 CCGs in England will be abolished.

Law change to make Integrated Care Systems legal entities

They will be replaced by around 40 Integrated Care Systems (ICS). Our local health care will then be managed by an ICS that covers Oxfordshire, Buckinghamshire and West Berkshire (BOB) with a population of over 1.8 million. With a committee managing health care over such a large area, the immediate problem that arises is accountability, transparency, and scrutiny.

The plans so far propose a Scrutiny Committee of nineteen members for the whole BOB area appointed by the local authorities and meeting twice a year. This is a drastic reduction in democratic oversight, little more than a rubber stamping machine. This BOB committee would be in addition to the local HOSC. According to the Terms of Reference published by the Council, the local HOSC will continue to function but the scrutiny functions that it will perform are not yet clear. A letter sent to the ICS representing the views of the local authorities expressed concern about scrutiny of ICS decisions:

"There was general concern expressed about the overall accountability of the ICS and the transparency around the current decision-making process. Members felt that there needs to be a greater level of transparency and independent scrutiny around the decision-making, particularly at the BOB ICS level."

KONP and other health campaigns have always demanded an end to the system of contracting health care to the private sector. The draft legislation will end the legal requirement established in the Health and Social Care Act of 2012 to put services out to competition. But this doesn't mean an end to private contracting. The involvement of the private sector in the management of the Coronavirus crisis clearly demonstrates the government's commitment to the healthcare market. The *scale* of such contracts in the larger ICS area would make them even more attractive to the private sector.

The aim of the proposed legislation is not to restore the NHS as a publicly delivered health service. The *aim* is greater efficiency (lower cost) and more central control. Each ICS will have a "single pot" from which to manage not just all health budgets but also capital spending. The secretary of state would acquire "new legal powers of direction" and each ICS would have a chief officer appointed from above. These plans are being rushed through without adequate consultation. Organisations have until 8 January to give their views on the proposed changes.

Key questions remain: What powers of scrutiny will local and ICS scrutiny committees have? How will the public be involved/participate in ICSs? To whom

Statement by Doctors in Unite

ICSs have been introduced and developed undemocratically, without consultation and with a lack of transparency. Their aim is to impose 'reduced per capita cost' control totals to force unproven and unsolicited innovation, including elements of privatisation and paid for care, in each system's struggle to meet local population need. This has been NHSE/I's practice with individual Provider Trusts over recent years. Each ICS will form a new Integrated Care Provider (ICP) organisation. NHS England plans for ICP organisations to be managed through commercial contracts..
https://doctorsinunite.com/2020/11/05/statement-on-integrated-care-systems/

are ICSs accountable - to government? to local authorities? Will ICSs be required to regard the NHS as the default provider? Will private sector contracts remain commercially confidential?

Rationing of NHS treatments in Oxfordshire

Case studies: 1. Ear wax treatment

In the October briefing we reported on the 'Lavender Statements' of the local CCGs which governs rationing of treatments available to Oxfordshire patients. We reported the range of such treatments, and the likely impact of rationing here. In this briefing we explore in more depth one of these treatments – 'Management of Earwax'. It is available to read here on the CCG website. Some of the suggestions, to soften the earwax before going to the surgery, are simply routine requests made by surgery nurses for decades. But the overall impact of the Statement has been to reduce access to this treatment, which has a big impact on people's health.

Earwax may seem a small thing but, judging from the increasing number of ads for do-it-yourself remedies that to us look frankly dangerous – one is a kind of screw-in q-tip – this is a treatment much needed, a treatment for a condition that considerably hampers quality of life.

Here is testimony from one of our members who would probably now not be offered ear syringing if they asked for it :

> ***'I have benefitted within the last year from removal of earwax by a nurse at our local surgery. Without it my hearing would have been annoyingly impaired. Over the years I have had to have it done several times. A comprehensive health service must include services like this as a matter of course. This is exactly the sort of thing that keeps people independent and able to look after themselves.'***

And here two instances of difficulties encountered by patients: one, a young man whose hearing was severely compromised by wax, told by the local surgery that they couldn't help and that he should get it done in the high street. The other, a patient who has regularly visited the ENT department at the JR, who was forced to email the ENT boss, the Chief Executive of the hospital, and the Chief of the

Hospital Board before gaining an appointment.

Anecdotally we are told the only way round this is to plead deafness – the audiologists insist on your ears being syringed before they will test! The Lavender statement itself does provide for exceptions and does not preclude the treatment entirely. But Oxfordshire patients record a severely reduced access to a simple, cost effective treatment which can and does improve quality of life.

KONP Oxfordshire intends to pursue these cuts and how they affect us all.

If you have a story of any other stolen treatment please contact Liz at eaperetz@gmail.com

Plan to scrap GP surgery at Wolvercote Mill site

Local people are dismayed by the news that a developer, CALA Homes, wants to build flats on a site previously earmarked for a GP surgery. The developer has submitted an application to the City Council asking it to allow the site to be used for the construction of new flats. See the full story in the Oxford Mail.

Published by Oxfordshire Keep Our NHS Public

https://keepournhspublicoxfordshire.org.uk/

Contact Oxfordshire KONP: bmackeith@gmail.com