THE lowdown

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

More fake promises in Tory manifesto

John Lister

Prime Minister Boris Johnson is at least consistent in one respect: his major statements begin to be discredited within minutes – as soon as anyone can check the details. Just recently we have had false and discredited claims on:

£1.8 billion of "new money" for capital investment, most of which was not new

Claims to be building 40 new hospitals – when the real figure is six, some of which are rebuilds, with decisions on the others not due until at least 2025.

Claims to be spending "record amounts" and £33.9 billion extra by 2024, when the real terms increase is just £20.5 billion, a 3.1% annual increase, much less than the pre 2010 average annual increases, and less than the 4.1% called for by the BMA and leading think tanks.

The launch of the threadbare 59-page Conservative Manifesto was another classic example. Headlines were first grabbed by a promise of 50,000 "more nurses," although committing to no timescale and not defining whether this is full time equivalent or a headcount.

Debunked

This was swiftly debunked, by the *Guardian* and *Independent,* by *Nursing Notes* and by Full Fact. *The Independent* pointed out that at most 31,500 would be "extra" nurses:

"The 50,000 figure includes an estimated 18,500 existing nurses who will be encouraged to remain within the NHS or attracted back after leaving …. The recruitment plan also includes 14,000 new nursing training places … as well as 5,000 more nursing apprentices and 12,500 recruits from abroad …."

The viability of recruiting so many overseas nurses given the brutal immigration policies unveiled by the Johnson government has also been questioned by *Nursing Notes* and the Royal College of Nursing.

Full Fact has also raised doubts over the minimal £879 million allocated to funding the extra nursing staff and reinstating the bursary for student nurses that was axed by the Tories — with a minimum of £5,000 per year.

They argue that the full cost of employing 50,000 Band 5 nurses could be as high as £2.6 billion per year. And with the latest figures showing 39,500 nursing posts vacant, an extra 50,000 would increase numbers by just 10,000.

The promise of 6,000 extra GPs also grabbed attention, with the related promise of 50 million more appointments each year. The promise had already been made by Matt Hancock – and exposed by *Pulse* magazine as another misleading claim, including 3,000 trainees along with 3,000 qualified GPs in the total.

Launching the manifesto in Telford, Johnson even managed to mislead on the planned downgrade of the local A&E unit, falsely claiming it had been saved – until a later statement confirmed the downgrade.

The BMA response to the Manifesto pledge pointed to the abysmal failure of governments since 2015 to deliver on Jeremy Hunt's infamous promise of an extra 5,000 GPs by 2020: in fact numbers have fallen by 1,000 in the past five years.

So what of the Manifesto promise to scrap fees for parking at English NHS hospitals, billed by the *Sunday Telegraph* as axing charges for "millions"?

The *Mirror* was the first to look closer and show that the promise is very cagey, making parking free only for those "in greatest need". So unless you are disabled, a "frequent" outpatient attender, a parent of a sick child staying overnight or a night shift NHS worker you will still have to fork out: the majority of staff, outpatients and almost all hospital visitors will still have to pay.

And so it goes on: other pledges are equally slippery and misleading. Social care is fobbed off with an extra £1 billion a year, and the problem kicked back into the long grass. Mental health gets another gush of warm words, but no new resources.

Voters who want a decisive break from the current crisis and decline of the NHS will need to look to parties other than the Tories.

The Lowdown will soon publish an overview of the manifestos of all the main parties.

IN THIS SECOND PRE-ELECTION ISSUE

Desperate shortage of mental health care for young people

The chronic lack of provision of child and adolescent mental health services has been repeatedly highlighted by reports from the charity YoungMinds.

The failure of government and NHS England to invest in supportive services ignores statistical evidence showing the scale of the problem, with 1 in 8 children having a diagnosable mental health disorder, and 1 in 6 young adults (aged 16-24) showing symptoms of a common mental disorder such as depression or an anxiety disorder.

The death toll is rising, with suicide the most common cause of death for both boys (16.2% of all deaths) and girls (13.3%) aged between 5 and 19 in 2017.

And where mental health problems continue, they are life limiting: people with severe mental health illnesses tend to die 15-20 years earlier than those without.

Target of 35%

In 2016 NHS England's document Implementing the Five Year Forward View set an uninspiring target of reaching 35% of children and young people with mental health needs by 2020

In January NHS England's Long Term Plan claimed that "access is rising in line with our plans and, in 2017/18, around 30.5% of children and young people then estimated to have a mental health condition were able to benefit from treatment and support, up from an estimated 25% two years earlier."

But the gaps are still enormous.

YoungMinds asked more than 2,700 young people about their experiences of looking for support for their mental health: fewer than one in ten (9%) said that they found it easy to get support, and only 6% of young people who had looked for support agreed that there is enough support – 81% disagreed.

Of those who had received support from Child and Adolescent Mental Health Services (CAMHS), many had experienced delays at every stage: 44% said that they found it hard to get a referral, 61% said that there was a long wait between referral and assessment, and almost a third (32%) said there was a long wait between assessment and treatment

Only 11% said that they had received support from CAMHS and didn't face any barriers.

GPs can't cope

A YoungMinds survey of 1,008 GPs published in early November found that 90% of GPs had seen a rise in the last three years of young people seeking mental health help, but over three-quarters of them (77%) felt community support for child mental health problems was not good enough, and almost the same number did not feel confident that their referrals to CAMHS would result in treatment.

Mental health charity Mind revealed the latest figures from NHS Digital show a big increase in the number of cancelled appointments by CAMHS has increased since 2017-18.

175,094 appointments in CAMHS were cancelled between August 2018 and July 2019 – an increase of 34,767 (20%) from the previous year.

One in five

Only in five of the GPs surveyed by YoungMinds said they had received enough training to handle mental health issues in young people: 59% disagreed.

Almost half of the GPs said they often acted beyond their competency by supporting young people with mental health problems.

The Guardian has highlighted NHS figures that show average waiting times to access CAMHS in England have fallen slightly, from 57 days in 2017-18 to 53 days last year. However, that does not include under-18s who were referred but still waiting at the end of the year to hear from the NHS as to when they would be seen.

The number of young people referred to CAMHS rose by 18% from 343,386 in 2017-18 to 405,479 in 2018-19.

Latest figures confirm downward trend in NHS performance

In October only two out of 119 hospitals with a major A&E department met the target of ensuring patients wait no more than four hours from the decision to admit until admission: more than 80,000 patients waited more than four hours, 63% higher than a year ago.

Of these, 726 patients waited more than 12 hours (240% higher than in October 2018).

Around one in six of those attending an A&E were not seen, treated and admitted or discharged within 4 hours, described by King's Fund chief executive Richard Murray as the worst performance since records began, "and this before winter has even started".

The target to admit, discharge or transfer at least 95% of people within 4 hours of arriving in A&E has not been met since the second quarter of 2014/15. However most of the delays are in the treatment of the more serious "Type 1" A&E attenders: Over 99% of minor (type 3) patients were seen within the 4-hour target time in A&E departments in 2018/19, in comparison to just 81.4% in major (type 1) A&E departments.

Just 77% of patients had their first definitive treatment for cancer within 62 days of an urgent GP referral in September 2019, down from 78% at the end of September 2018, and well short of the operational standard that specifies that 85% of patients should be treated within this time.

Delays in discharging patients after their treatment amounted to 149,384 days in September 2019, an increase of 3% from September last year. These days equate to a daily average of 4,979 beds (equivalent of ten general hospitals) occupied by delayed patients in September 2019 compared with 4,820 last year.

The main reason for delays in September 2019 was "Patients Awaiting Care Package in Own Home", which accounted for 21% of all delays. Half of the delays for this reason are attributable to Social Care, 30% to NHS and 20% to both.

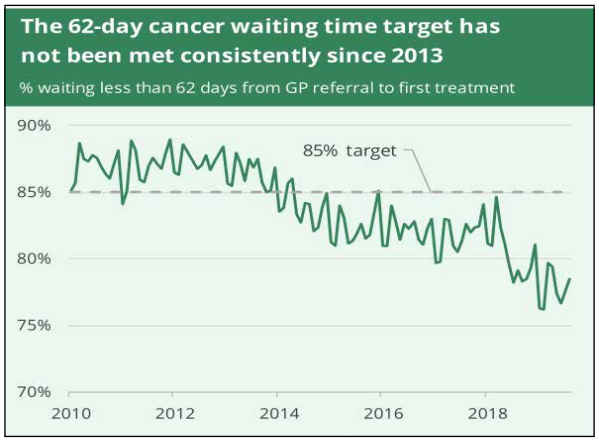
Social care has suffered real-terms cuts, with

Death toll from social care

The actual austerity-driven cutbacks in social care spending that have continued since the 2017 general election have taken a heavy death toll according to research by Age UK. They calculate that 74,000 or more older people have died waiting for social care, equivalent to 81 per day – more than three per hour.

1.7 million calls for help and support went unanswered, many of them because people were deemed not sufficiently serious to meet tough eligibility criteria for social care.

Age UK's manifesto for the 2019 election estimates that 4.1 million of England's 10 million people over 65 are in poor health, living with one or more serious long term health condition: more than a third of these (1.5m) have an unmet need for care – ranging from help with washing, dressing

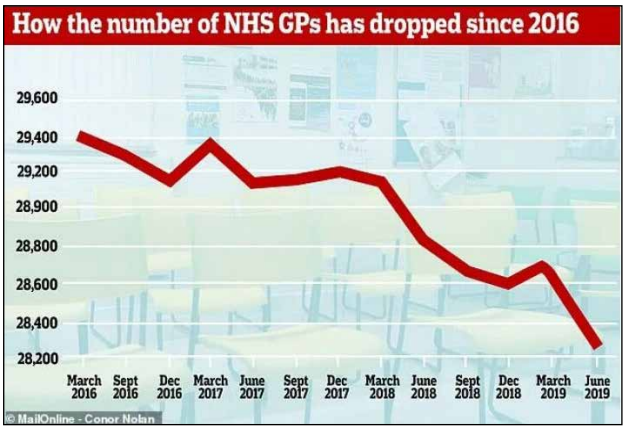


government spending on adult social care in England cut from an average of £346 per person in 2010/11 to £324 in 2017/18.

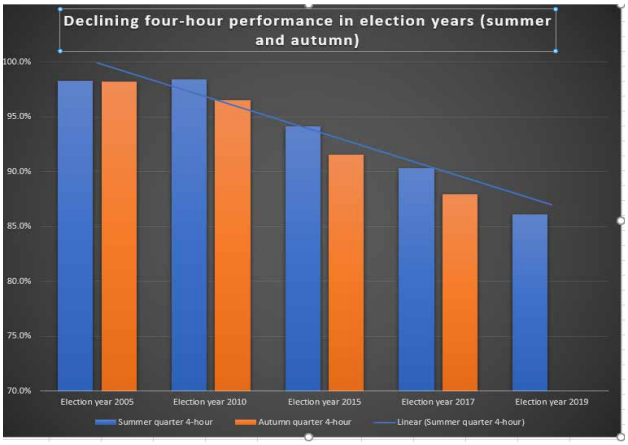
85% of patients on the waiting list for elective treatment at the end of September 2019 had been waiting less than 18 weeks, well short of the 92% standard, and down from the 86.7% in September 2018: the number of patients waiting over 18 weeks rose 22% from 550,000 to 672,000.

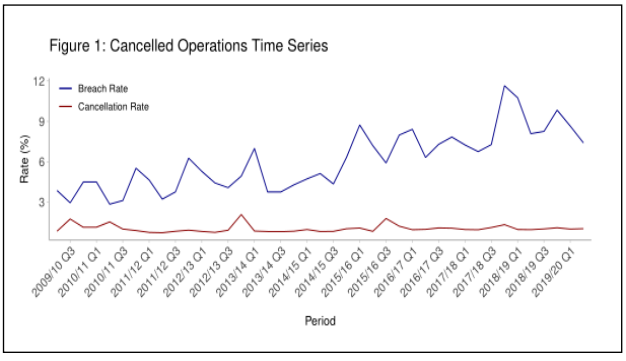
The Health Foundation points out that people are being added to the elective waiting list faster than the NHS can treat them. "The total number of people on the waiting list is now over 4.5 million, having grown steadily from 2.5 million in April 2010."

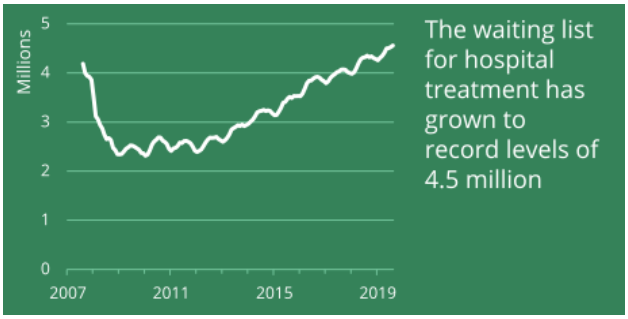
While numbers of diagnostic tests have increased over the past year, 3.8% of the patients waiting for one of the 15 key diagnostic tests at the end of September 2019 had been waiting six weeks or longer from referral, compared with the operational standard of less than 1%.



Delays in discharging patients after their treatment days equate to a daily average of 4,979 beds (equivalent of ten hospitals)







cuts: over 3 people per hour

and using the toilet to more intensive support in a care home.

Age UK says it estimates the number will rise to 2.1 million by 2030 if governments fail to act. It is calling on the next Government to secure the immediate future of care through investing at least £8 billion over the next two years.

1.6m older people are living in poverty. Around one in ten older people live with frailty.

Improvements in healthy life expectancy have peaked in recent years, especially in deprived areas, where at age 65 people can expect 7 fewer years in good health than those in the wealthiest areas.

Social care spending on over 65s was cut by 25% between 2010 and 2018.

■ While Health Secretary Matt Hancock and NHS England are obsessed by digital solutions and apps, 3.4 million over 65s have never used the internet, and another 500,000 have done in the past but no longer do so. Most over 75s are not online.

Public health cuts expose hollow claims of "one nation" approach

Public health cuts have been biggest in poorest areas

Boris Johnson opened his election campaign with a fresh claim to be a "one nation" Conservative – after expelling two dozen actual one nation Tories who refused to vote for his 'deal'.

The term "one nation" was originally coined by Tory Benjamin Disraeli back in the 1830s in reference to the need to reach out for support to the working classes: since the 1940s it has generally meant a paternalistic view of the welfare state.

But of course the welfare state has since been savaged by the Thatcher government in the 1980s and the Tory-led governments since 2010, with austerity-driven cuts that have widened inequalities between different areas and between rich and poor.

Now as he bids for the votes of pro-Brexit workers, Johnson appears to be donning the "one nation" mantle.

The Independent reported: "In an attempt to drag his campaign back on track, Mr Johnson vowed to usher in a "One Nation Conservative" government that would focus on making the UK the "greatest place to live, to raise a family, to start a business, to send your kids to school"."

But evidence of his party's commitment to the opposite approach can be found in the hefty cuts in public health spending that have been imposed in the past 5 years, which land most heavily on the poor, and help to further widen the inequalities in healthy life expectancy between the richest and the most deprived areas.

Local government spending

A recent report from the IPPR has brought together the evidence and calculated the scale of the cutbacks in public health services, which have been driven on by a truly massive 60% cut in local government budgets between 2010 and 2020.

The decline in public health spending adds up to £850m since 2014, with the main cuts imposed on drug and alcohol services (£261m), and sexual health services (£196m): there have also been cuts in smoking cessation initiatives (£85m), health checks protection and advice (£72m) obesity services (£26m) and "miscellaneous" public health services (another £220m).

Public health spending has been reduced from a peak of £2.9 billion to £2.3bn across the whole of England, less than 2% of the NHS budget.

Annual spending has been reduced from a peak of £2.9 billion to £2.3bn across the whole of England, less than 2% of the NHS budget.

Each of the cutbacks undermines the health of local populations but also increases the longer-term burden on the NHS and other public services.

Poorest cut hardest

But the IPPR points out that the heaviest cuts have fallen on the areas of highest need and deprivation. Fifteen percent of all cuts (almost £1 in every £7) have hit just 7 percent of local government areas – the most deprived ten places.

These poorest areas "have lost approximately 35p in every £1 of their budget" for public health, and the cutbacks in these areas have been far higher on key services such as the national child measurement programme, obesity, drug and alcohol, and smoking, while one of the few services to be increasing nationally, physical activity, is far better resourced in the richest areas (up 76%) compared to the 9% increase in the most deprived areas.

Theresa May's government agreed a one-off 1 percent increase in public health funding, well short of the £1 billion the IPPR calculates is needed to restore it to the 2014 level. Without real resources to address public health problems, any talk of "one nation" policies is a wilful deception.

Short term fix does not end pension tax fiasco

Matt Hancock may claim that the flawed "taper tax" on pensions affecting senior NHS consultants has been "scrapped immediately" – but this is flatly contradicted by the statements of NHS England and well-informed reporters.

The tax remains firmly in place, but NHS bosses and the government have bodged together a temporary fix. According to NHS England boss Simon Stevens "a substantive answer from Government to the tapered annual allowance issue now seems unlikely to take effect before the new tax year, from April 2020."

The Health Service Journal sums up: "A temporary 'solution' to the pensions tax impact on the health service has been confirmed by NHS England and signed off by government. … This stop-gap solution comes amid huge concern about senior doctors turning down additional shifts, because of the threat of large tax bills on their pensions."

However the HSJ points out that it's still not clear where the funding will come from to refund the tax payments that would initially be taken from consultants' individual pension pots, and refunded on retirement.

The Guardian notes that it is being presented as an "operational decision" by NHS England, to avoid criticism that it breaches "purdah" restrictions on new policy, "but was signed off – and some believe instigated – by the Treasury, Cabinet Office and the Department of Health and Social Care."

The lie that keeps on coming: claim to be building 40 hospitals

Matt Hancock, Michael Gove and others have been travelling the country repeating the claim that the Johnson government has launched "the largest hospital building plan in a generation, with 40 new hospitals across the country."

In fact all the Johnson government has done is provide £2.7 billion to fund just SIX new or refurbished hospital projects.

£100 million is also provided as "seed funding" for 21 trusts to draw up plans for another 34 hospital projects – which will potentially cost another £10 billion or more – after 2025.

By comparison from 1997-2010 Tony Blair's government built well over 100 new hospitals – albeit funded through PFI.

It's also questionable whether the 34 future projects will ever get beyond the planning stage, since they would need to be agreed and funded by a future government after at least one further election, during or after 2025.

None of the six new hospitals that have been given the "immediate" go-ahead is ready to start work for many months yet. In some cases it's already clear that the amount of capital allocated falls short of the amount needed.

The lie that EU nationals working here don't pay tax

Claim: "It's unfair that people coming from European countries can access free NHS care without paying in while others make significant contributions." - Michael Gove, Mail on Sunday, Nov 17

Gove's claim has been angrily rejected. Nicolas Hatton, the co-founder of EU citizens' rights group the3million, told the Guardian: "It's a cheap political ploy based on xenophobia designed to get votes."

"EU citizens do not have automatic rights to health systems in EU states," he said.

"In the first three months, you are treated like a tourist with no rights, and after three months, unless you are working or are self-sufficient, then you have no rights to the NHS."

Labour MEP Claude Moraes said "The line that Gove used about 'paying into' the NHS is really an old-style racist trope and is designed to target Labour marginals where the vote is about leave or remain. You can't "pay into the NHS" even if you wanted to."

Shadow home secretary Diane Abbott also intervened on Twitter to argue:

"Michael Gove is completely wrong to say people from EU are accessing the NHS without 'paying in'.

"EU workers pay taxes. The NHS is not a contributory system.

The government's own Migration Advisory Committee report in 2018 concluded "There is no doubt that EEA migrants contribute more to the health workforce than they consume in healthcare. This can be explained by their age profiles, they tend to be younger than the make-up of the resident population."

The lie that the NHS would be off the table in any future US trade talks

US President Donald Trump stated clearly during his visit to England in June this year that the NHS and its £120bn budget should be "on the table" in any trade talks.

Subsequent efforts by PM Johnson and his ministers to undo the electoral damage that this could cause among their own supporters have relied on us accepting Johnson's own assurances and the attempt by Trump the following day to tone down what he had said.

But can Johnson's protestations be taken seriously? It's clear from a Times report back in September 2018 that the "Initiative for Free Trade", a right wing "think tank" closely linked with senior Conservatives (former ministers Liam Fox, David Davis, along with ERG chair Steve Baker and Tory MEP Daniel Hannan, has explicitly called for the NHS to open up contracts to run NHS hospitals to US corporations.

Now the Led By Donkeys campaign has unearthed evidence including video footage of the launch of this IFT report, and confirmed that it was hosted by Boris Johnson in the map room of the Foreign Office, with taxpayers picking up the tab for the £6,000 event. There is footage of Johnson himself introducing it as a "crucial" event and seated as the proposals were unveiled.

Since then Jeremy Corbyn has confronted Johnson with the leaked document proving that preliminary discussions on "full market access" to the NHS have already been held with US trade representatives. It seems the more they deny involvement the less credible they become.

Staffing crisis puts patients at risk

Tackling the growing NHS staffing crisis is ranked as a key priority for the next government by 94% of hospital chief executives and chairs, with more than half putting the issue as number one on their list, according to a new survey by the NHS Confederation.

More than nine out of ten senior managers (91%) agreed or strongly agreed with the statement 'understaffing across the NHS is putting patient safety and care at risk.

Vacancies

The NHS Confed repeats widely-shared estimates that there are more than 100,000 FTE vacancies in England in hospital and community services alone, and emphasises that the problem has been mounting over the past five years:

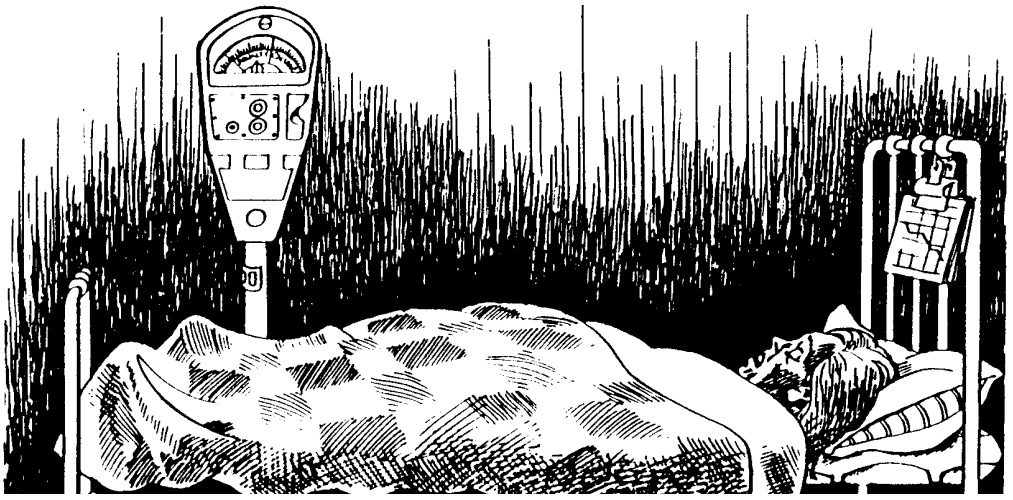
"In every month from 2014 to 2019 most hospitals were only able to fill their shifts using temporary and agency staff. This shortage is particularly pronounced in mental health and learning disabilities services, which have a disproportionately high number of vacancies."

The report also points to a slightly larger number of vacancies in social care, with around 122,000 vacancies: "around one in ten social worker roles and one in 11 care worker roles vacant."

The Confed warns that a no-deal Brexit poses risks when it comes to recruiting and retaining staff for the NHS and social care. 65,000 NHS staff, over 5% of the workforce in the English NHS, are EU nationals. And there is a warning as Tory ministers prepare to charge for visas and access to the NHS for future staff from EU countries after Brexit:

"Given the current shortfalls, it will be vital to enable and encourage overseas staff who want to come to work here and make sure they have the means to do so easily and with confidence about their future status.

"Whatever happens with Brexit, future immigration policy must take into account the staffing needs of both the health and care systems."



Private hospital chiefs stung by threat to their NHS income

John Lister

The Labour Party's promise to "end and reverse privatisation in the NHS in the next Parliament" has triggered a tetchy response from the private hospital chains, which have been doing good business and filling their otherwise empty beds with NHS-funded patients

The Independent Healthcare Providers Network (IHPN) claimed (perhaps having just listened to Boris Johnson's inflated promises) that "over 40" new NHS hospitals would be needed if a Labour government prevented private hospitals from delivering care for NHS patients, and warned that waiting lists for specialist care could treble in three years.

They went on to claim the private sector performed 11.2% of all non-urgent care, which they say was 436,000 operations a year. The IHPN's chief executive David Hare argued that this proved the "vital role" private providers play.

NHS trained staff

However the boot is on the other foot. Without the medical, nursing and professional staff trained and largely employed by the NHS when not doing shifts in private hospitals, and the availability of NHS emergency and intensive care facilities for the cases that go wrong, the private hospital sector would collapse.

Indeed the more the private sector expands, the more they tend to poach further scarce NHS staff, and put greater pressure on NHS hospitals which are responsible for the full range of health services.

However their calculations seem wide of the mark in almost every respect.

According to the main market analysts Laing & Buisson, there are **197** private hospitals licensed to take acute patients, with 9872 beds between them, **averaging just 50 beds** per hospital: this underlines how limited is the range of services the private sector is set up to deal with, with no emergencies to deal with.

9872 beds is the equivalent of around **20 district general hospitals** with 500 beds – not 40. But since many of the private sector hospital beds are under-occupied and providing only a limited range of elective procedures it's not at all obvious they would all need to be replaced.

By contrast the NHS has just over 100,000 general and acute beds, mostly in full service general hospitals.

Mental health

The situation is very different in mental health, where the private sector expansion has been the greatest.

Laing & Buisson estimate there are 8942 private beds funded by the NHS, but give an inflated figure of 23,596 public sector beds: in fact the latest NHS figures show just 18,179 mental health beds after a decade of cutbacks, so the private sector is currently providing around a third of mental health in-patient capacity, much of this through companies that are now owned by US corporations.

However the IHPN is not concerned with mental health: its focus is on acute care, and here too there numbers are questionable, and the basis on which they have made their calculations is not explained.

The NHS in England delivered **8.8 million elective admissions** in 2018-19: so 436,000 operations is not equivalent to 11.2% of all non-urgent care, but **just under 5%**.

Private sector apologists also argue that private hospitals are only paid the standard NHS tariff for the publicly-funded patients they treat – but they don't do the standard type of NHS work. They take a very different, more restricted caseload, accepting only the least complex or risky cases, while the NHS has to accept all comers.

It's high time there was a real audit of the costs – overt and hidden – of the private sector: if there was, the IHPN would have to come up with some more plausible figures.

Surcharge to be increased to £625

Ministers inveil new plans to deter health workers from coming to Britain

John Lister

The *Daily Mail* could barely conceal its joy as Tory ministers spelled out new ways in which a re-elected Johnson government would "get tough on post Brexit migrants" – and jack up the "Immigration Health Surcharge" (HIS) from £400 to at least £625 per person.

This is just one of a nasty "battery of measures" to delight the immigrant-hating *Daily Mail,* but of course it would be additional deterrent to any potential health professionals who might consider coming to work for our NHS, including some of those who until the Brexit vote were coming in numbers from the EU:

"after Brexit, all foreign patients – including those from the EU – will have to pay a £625 fee, which is expected to raise an extra £500 million a year for the NHS."

Half price visa

It was only a couple of weeks ago Johnson announced that health workers would be encouraged to come to Britain by a special half-price visa (although, as we explained in our last issue, for EU nationals it is not a halving of price, but a new imposition of a £464 fee).

The 50%-plus increase in the IHS, pushing the up-front cost of coming here to more than £1,000 in addition to regular taxes is an added deterrent, despite the desperate staffing shortages in the NHS.

The latest increase in charges is the outcome of a relentless campaign by the *Daily Mail* and other right wing newspapers, which have peddled the myth of "health tourism", and hugely inflated the costs of treating the small numbers of overseas visitors who make use of NHS treatment.

In October the *Mail* headlined a largely fictitious "calculation" by unnamed Department of Health bureaucrats, which claimed that the IHS had been set too low at £400 because "Each payer of the IHS ends up costing the NHS an average of £625 a year."

In 2018 Immigration Minister Caroline Nokes claimed that the health department had been modelling the costs incurred by IHS payers and estimated it as averaging £470.

Now the *Daily Mail* is quoting new figures, allegedly "based on actual usage by IHS payers", showing that, on average, each IHS payer cost £631: "£88 in GP appointments, £35 in dental and eye care, £55 in prescriptions, £237 in hospital care including A&E, and £216 in other costs, including ambulance services, mental health and administration."

The document containing these imaginary figures has of course not been published, nor has any explanation been offered of its completely implausible assumptions on the scale of use of the NHS by migrants.

Not only do migrant workers who pay the surcharge also pay the same level of income tax and other taxes which fund the NHS, but there is evidence showing that migrants often use the NHS less than native populations:

"People who migrate tend to be younger and healthier than native populations. Older people and those with disabilities and severe illness are less likely to move, apart from in extreme circumstances. This underpins a longstanding epidemiological phenomenon, called the "healthy migrant effect"

The King's Fund argues that "The average use of health services by immigrants and visitors appears to be lower than that of people born in the United Kingdom, which may be partly due to the fact immigrants and visitors are, on average, younger."

The Health Foundation points out that: "'Migrants are good for the NHS. Existing evidence shows that immigration makes a positive contribution to the UK health service. Migrants contribute through tax, tend to use fewer health services compared to others, and provide vital services through working in the NHS."

Sadly such evidence is unlikely to deter Tory ministers seeking votes by playing up the prejudices and ignorance of racists or the Daily Mail playing to its most xenophobic readers.

Ambulances queued outside Peterborough City Hospital - photo Peterborough Live

Pre-winter crisis in A&E

As performance levels of acute trusts plummets and the winter draws near, with no additional winter funding made available to trusts this year by NHS England, the relatively new PFI-funded Peterborough City Hospital is giving cause for concern.

Delays of up to 6 hours in transferring emergency patients from ambulances in to the Emergency department have been reported to the local newspaper.

The percentage of A&E patients treated, discharged or admitted within the target 4 hours has fallen from 92.6 a year ago to just 75.8 in October, while the number of hours ambulances have been stuck outside the hospital unable to hand over patients has almost trebled from 312 to 886 in the same period.

Worryingly the latest A&E performance figures indicate that these are far from the worst-performing trusts in England: on the October figures the bottom of the heap for treating the most serious Type 1 A&E cases within 4 hours is **Lancashire Teaching Hospitals**, bumping along at less than half the target percentage of 95%: **eight more** trusts are scoring below 60%.

The bottom ten performing trusts include **Hillingdon Hospital**, local to Boris Johnson's constituency. He will no doubt be hoping his constituents remain unaware of this failure so close to home.

Ten trusts with longest waits for Type 1 A&E in October 2019	% within 4 hours (target 95%)
Lancashire Teaching Hospitals FT	**46.7**
Blackpool Teaching Hospitals FT	**52.7**
Barking Havering & Redbridge	**53.3**
United Hospitals Lincolnshire	**56.7**
Shrewsbury & Telford	**57.9**
King's College Hospital FT	**59.3**
Norfolk & Norwich Hospital FT	**59.3**
Croydon Health Services	**59.6**
Wirral Teaching Hospitals FT	**60.4**
Hillingdon Hospital FT	**60.6**

A&E Attendances & Emergency Admission monthly statistics, by Provider, October 2019

Simon Stevens: five years of failure that have plunged NHS into growing chaos

John Lister

The latest, shocking statistics showing the scale of the decline of NHS performance on almost all of its key targets raise serious questions, not only about the need for more staff and more funding to run services and invest in new and improved buildings and new equipment, but also about the senior management of NHS England and its chief executive Simon Stevens.

The priorities, policies and attitude to staff and to public accountability of Stevens and the team around him have shaped the service, and must be seen as partly responsible for the decline in performance of NHS services.

They must also share the responsibility for the grim revelations of the scandals of mistreatment of maternity cases in Shrewsbury and Telford Hospitals Trust, which seem certain to reach a scale far worse than the previous worst maternity scandal at Morecambe Bay, and eclipse the scale and severity of the Mid Staffordshire Hospitals scandal in the mid 2000s.

If Stevens had performed on a similar level as manager of a Premier League football team or many private businesses he would have been out on his ear several years ago.

It's now more than five years since Stevens, a former Labour councillor and advisor to Tony Blair's government, took over at NHS England after working nine years as a vice president of US health insurance giant United Health. Six months later he published a major policy document, the Five Year Forward View (FYFV).

Looking back at the 44-page FYFV is like stepping into a museum: most of the key commitments have long ago been sidelined or reduced to token gestures, not least the insistence that:

"The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."

But while the plan presumed improved public health, since 2014 we have seen year after year of cuts to public health budgets which are supposed to fund schemes to help tackle obesity and reduce consumption of alcohol, drugs, and tobacco. This is not Stevens' fault: but what is his fault is that his plan rested on such unrealistic assumptions.

Main ideas

Many of the main FYFV ideas, whether people agreed with them or not, have also remained little more than words. For instance patients were to be given control over shared budgets for health and social care – a controversial idea with many campaigners, and one which lacks sound evidence that it can work in the NHS. Stevens in a July speech in 2014 suggested "north of 5 million" such personal budgets might be operational by 2018, sharing £5 billion between them.

But this apparently bold proposal, if funded at that level, would have meant average payments of just £1,000 per year, £20 per week – well short of the amount

required to secure any meaningful care package for any but the most minor health needs – even if the services required were available, and the patient/client was confident enough and able to sort out their own care.

Moreover the latest figures show that the vision was unrealistic on almost every level: the number of personal health budgets has apparently been rising each year since they launched in 2014, but there were fewer than 23,000 people receiving one in the first nine months of 2017/18 – a long way short of 5 million.

Carers, too, were promised new support by the FYFV (not for the first time, and no doubt not for the last). Yet the plight of carers remains desperate, with increased misery for many of them hit by the succession of welfare cuts and the nightmare of universal credit.

Barriers

According to the FYFV, barriers between GPs and hospitals, physical and mental health and health and social care were going to be broken down.

A "Forward View" for GPs has since been published: but there was also supposed to be a shift of investment from secondary care into primary care, which has not happened (how many times have governments proposed that since the 1980s?).

So barriers are still intact. Overworked, under-staffed GPs face ever-increasing demands, with no sign of the promised increase in numbers or resources; in frustration they are now calling for an end to the requirement to do home visits.

The FYFV also made bold promises to invest in more staff and improved services for mental health. Predictably none of these things have happened. Instead there are still thousands fewer mental health nursing staff now than there were in 2010, and the performance on almost every measure is as bad or worse than 2014.

It also went on to propose new "models of care", including Primary and Acute Care services (PACS).

Stevens compared these with "Accountable Care Organisations that are emerging in Spain, the United

States, Singapore, and a number of other countries."

Given his previous employment, this understandably led to widespread fears of 'Americanisation' – despite the fact that few such organisations have been proposed here, and even fewer launched, none of them involving private companies.

Long Term Plan

After such a comprehensive failure to deliver almost any significant element of the FYFV, the likelihood of making the TEN year Long Term Plan (LTP), published back in January, any more than a wish list or a pious declaration seems to be vanishingly small.

The Long Term Plan does contain a few positive concessions to the pressure of campaigners and the needs of patients:

- New waiting time targets are to be introduced for adult and child mental health – although these are far from ambitious and without extra funding imply cutbacks elsewhere;
- A promise of action to address unexplained mortality for people with learning disability and autism and the long waits they experience;
- No explicit call to close acute hospital beds;
- The idea is floated that the NHS take back responsibility for some public health provision.

These few positive elements must not distract us from the hard proposals in the LTP for a further top-down reorganisation of England's NHS – into a centralised structure of 44 "Integrated Care Systems" (ICSs) which are to "grow out of the current network of Sustainability and Transformation Partnerships" (STPs) within two years.

They are to be policed by regional directors and a network of 'joint NHS England and NHS Improvement regional directorates' announced in November. That's the meat of the Plan.

As proposed in the LTP, none of these new structures will be in any way accountable to the local people and communities they cover.

Each ICS would work to an 'Integrated Provider Contract' – along the lines proposed by NHS England in 2018, and opposed by many campaigners. Once again there is no guarantee that the new contracts could not be sub-contracted to the private sector.

The Plan also requires a series of mergers to reduce from 191 Clinical Commissioning Groups to just ONE CCG per ICS. The remaining CCGs are also required to cut their management costs by another 20%, ensuring they are reduced to rump bodies with residual token power, in practice accountable to nobody. Trusts, too, would be required to collaborate with the wider ICSs.

With local authorities once again not even consulted on the Plan, it's clear that just like the "Sustainability and Transformation Plans" that were hatched up in secret in 2016, none of the Plan would be subject to any consultation with staff, the public, or anyone else.

CCGs and trusts with the toughest financial problems, and often with the most inadequate resources, face the hardest targets and the harshest treatment.

Private hospitals

Tucked away in the Plan are more hard-edged proposals for increased use of private hospitals to deliver NHS funded care to limit waiting times (already being surreptitiously driven through by NHS England), as well as new pressure on trusts to increase their links with the private sector to "grow their external (non-NHS) income" and "work towards securing the benchmarked potential for commercial income growth."

There also is an implicit threat of privatisation in the LTP proposals for new pathology networks and imaging networks to be established, in the absence of the necessary NHS capital for investment.

Trusts are told they must also aim to increase the funds they get from charging patients for treatment – "overseas visitor cost recovery" – a policy which will raise little money in relative terms, but which will deter some patients from accessing the services they need, undermines the principles and values of the NHS, and which is opposed by the medical Royal Colleges.

CCGs and trusts with the toughest financial problems, and often with the most inadequate resources, face the hardest targets and the harshest treatment.

The Operational Planning and Contracting document, published on December 21 2018 (and subsequently re-issued in January 2019) set out proposals for "savings" of more than £200m a year to be delivered from restrictions on GPs prescribing a growing list of drugs and treatments.

Some CCGs have already gone well beyond the initial list of exclusions drawn up by NHS England, and in a number of cases the private sector is eagerly lining up to offer to sell patients the operations and treatments they can no longer routinely get on the NHS.

To sugar the pill, the Long Term Plan has to say something and so it rattles out upwards of 60 uncosted commitments to improve, expand or establish new services. Most of them, if taken at face value would be most welcome – but taken together in this context they

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Five years of failure

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are completely unaffordable, unrealistic and incapable of implementation.

There is promise after promise, many of them sounding great: prompt response services, proactive care, flexible teams, neighbourhood teams, primary and community care teams, community multidisciplinary teams and upgraded support. All these are presented in happy-clappy, completely abstract terms, without explaining how they were chosen, who would be responsible, or the timescale for implementation.

The Plan insists on a 'digital first' option for most consultations in ten years, a vision of future services that many patients would view with trepidation:

The obsession with digital access runs as a theme through the Plan, and ignores recent research that showed Skype-type online consultations are suitable for only small minority (2-22%) of hospital outpatients, with many clinics finding them completely impractical.

There is growing evidence of the weaknesses and limitations of the much vaunted "Artificial Intelligence" chatbot produced by Babylon, and similar digital innovations lack evidence they are effective, or cost effective.

Fatal omissions

Of course it's impossible to discuss the LTP's content without also addressing the vital issues that are omitted from it. An enormous number of major issues are either ignored completely or blithely brushed aside in the 136-page Plan.

These include the declining actual performance of trusts; the inexorable rise in emergency caseload; the insufficient capacity in acute and mental health services and bed shortages; the £6.6 billion and rising bill for backlog maintenance; the cuts inflicted in mental health and community services; the impact of repeated cuts in public health budgets; the widening gap in society between rich and poor and the resultant inequalities in health – exacerbated by unchanged austerity and reactionary government policies on housing, welfare, education, and local government:

and of course the gathering crisis of a dysfunctional social care system, for which the long-promised Green Paper has repeatedly been postponed.

No serious workforce plan has yet been published, and there is no evidence work on this has advanced at all; and there is clearly not enough money in the pot to pay for significant new ideas, or the extra staff that are needed.

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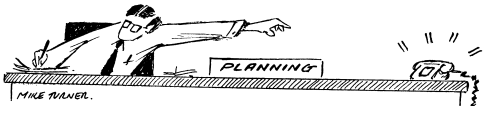

NHS England has also turned a blind eye to efforts by hospital trusts to dodge VAT and other taxes by transferring their own support staff against their will into wholly owned companies outside the NHS – thereby undermining the integrity of the existing workforce and quality of services (see page 11 opposite).

Funding gap

Every informed observer has warned that the famous £20.5 billion real terms "extra" funding over five years repeatedly announced since last summer [and now misleadingly rebadged by PM Johnson as a **£33.9bn** increase in cash terms] is not enough to do much more than slow the decline and keep the lights on.

It's clear that with the financial constraints limiting any real improvement, and a new system being imposed from top down and accountable only upwards to NHS England, patients and the public will have less voice and influence than ever in the shape of services and their access to them. Everything about us would be decided without us.

The Long Term Plan is a medium term threat to the services we all depend upon – and our ability to find out what's happening and fight back locally to defend the services we need.

There has been damaging privatisation, with plans for more, but so far US health corporations have made no real attempt to exploit the market established by the 2012 Health and Social Care Act to win contracts to deliver health care, hospital services or even health insurance in England.

They remain largely on the sidelines, seeking lucrative but relatively small scale back office roles in the NHS. If Simon Stevens is, as some believe, their Trojan Horse, their inside route to fully "Americanise" the NHS, there is little sign the conspiracy is succeeding.

Rather than focusing on how Simon Stevens is promoting US corporate interests we need to expose the many flaws inherent in his "reforms" and organisational changes since 2014. These changes have been:

- Outside the law, and therefore lacking, and avoiding, any proper scrutiny by parliament, local government or local people.
- Centred on creating local and regional level organisations which also lack any accountability to local communities
- Aimed at centralising services, at the expense of closures and downgrades of local A&E and other services, while lacking the capital to provide or expand alternative services
- Focused on inappropriate and ineffective US-style "integrated care" despite the lack of evidence this can really integrate services, limit demand for care, or deliver any significant benefit to patients.

Stevens and NHS England have ignored the continually worsening performance being delivered month after month by underfunded, overstretched and under staffed hospitals and mental health services.

The changes it has driven through are increasingly jeopardising patients' lives by putting front line staff under impossible pressure and worsening the recruitment and retention of staff vital to quality care.

The pattern has been one of consistent failure masked by the rhetoric of grand, impractical plans, few of which have been carried through.

It's time Mr Stevens was properly called to account, by a government that values the NHS.

Bradford strikers defeat privatisation

The Bradford Hospital strikers, who staged lively three weeks of strike action this summer, have won their fight to force the trust to drop plans to forcibly transfer them into a newly-created "wholly-owned subsidiary company" – Bradford Healthcare Facilities Management Ltd (BHFML).

Over 300 UNISON members, including domestics, porters and security staff, were determined throughout to retain their status as NHS employees and not to be dumped into the private sector as part of a bid to cut VAT and other tax costs.

They initially took one week of strike action, followed by a 2-week stoppage in August when management refused to budge: an all-out stoppage that had been unanimously agreed was suspended at the end of August to allow talks to take place.

Three months later these have eventually secured a decision of the Trust not to continue with plans to create a new company. All staff employed within Estates, Facilities and Clinical Engineering will remain directly employed by the Trust.

Commenting on the Trust's climbdown, UNISON general secretary Dave Prentis said: "It is time for NHS Improvement to stop trusts going ahead with these projects without staff support. This case sends a strong signal that the practice of creating subsidiary companies should be brought to an end completely."

The Trust had denied it was privatising services, insisting that the development of the new company was "essential." Even now it has been scrapped, Trust Chief Executive Mel Pickup said: "The reasons for seeking to set up the new company have not changed."

"We now must work together with staff and UNISON to find alternative ways to make productivity gains within these important support services."

■ A UNISON commissioned opinion poll early in November found a majority of the public opposed to transferring NHS staff to private contractors.

The UNISON/ComRes poll also found the vast majority (78%) of people believe non-medical employees are just as important to the health service as staff who deliver treatment such as doctors, nurses and midwives.

Frimley trust halts WOS plan

Plans for around 1,000 support staff at Frimley Health Foundation Trust's three hospitals – Frimley Park, Heatherwood and Wexham Park – to be transferred out of the NHS into a new wholly owned subsidiary (WOS) have been halted by the threat of a planned coordinated 48-hour strike by all three major unions.

At the last minute an agreement was secured over the weekend by UNISON, which represents the majority of porters, security guards, cleaners and catering staff employed by the Trust. The Trust gave a commitment not to continue with its existing plans while other options are pursued, including possible ways to keep the staff employed within the NHS. In view of this UNISON agreed to take no further action for the time being.

■ The other two unions, Unite, with 90 of its members at the Trust working in estates' management, equipment maintenance, catering, portering, procurement and security having voted 92% for strike action, and the GMB which had "drawn a line in the sand" against the WOS, went ahead with their action and public protests on November 18-19.

Warnings of the "technological wild west"

John Lister

Matt Hancock and NHS England are not the only eager advocates of digital technologies.

In June this year WHO Director-General Dr. Tedros Adhanom Ghebreyesus argued that "harnessing the power of digital technologies is essential for achieving universal health coverage."

However a Tek4HealthEquity conference in New York early in November has served to flag up some dangers that the fans of digital solutions are keen to bush aside.

A report from this conference by the Antwerp-based International Health Policies Network (IHP Network) warns that "rampant commercialisation and weak regulation challenge the ideal of digital public goods capable of reducing inequalities."

The authors point out that enthusiasm for digital health solutions reflects the broader technological optimism that has long characterised the global health field.

But it is "founded in the belief that market-based solutions and innovation-driven development will produce cost-effective solutions to solve the world's problems."

Discriminatory

They report that presentations at the conference highlighted "discriminatory design, high costs and weak regulations" as some of the challenges to the idea of digital public goods capable of reducing global and national-level inequities in health.

The conference's starting point was that digital technology is not neutral, "but is developed and deployed in specific social and political contexts, and is therefore susceptible to built-in biases, which can become embedded in the technology itself."

"A study recently published in Science revealed that an algorithm used by American hospitals and insurance companies to enable treatment that is more efficient systematically discriminates against black patients."

And "while commercial actors often reap heavy rewards, the solutions are not necessarily cost-effective for public authorities, nor do they always have proven health benefits."

Health care is facing a "technological wild west" in which ownership is concentrated among a few, dominant tech companies like Google, Facebook and Amazon combined with non-existing or inadequate legal and regulatory frameworks.

As a result, the authors argue "Before we conclude that digitalization benefits vulnerable individuals and accelerates improvements in global health equity, we need a closer look at which kinds of technologies are developed, for whom and with what purpose."

THE lowdown

In our first year we pledged to:

- establish a regular one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally.

To go into a second year we need **YOUR HELP**

The Lowdown launched in February 2019 with our first pilot issue and a searchable website. Our initial funding came from substantial donations from trade unions and a generous individual.

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – **something that was not previously available to NHS supporters.**

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

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

The aim of the project has been to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

To get it under way, we have worked hard to get the name established, build a core readership, and raise money where we can.

We need to make the project self-sustaining, so we can pay new journalists to specialise, and undertake investigations and research that other organisations aren't able to take on.


THE lowdown

Health news, analysis and campaigns. NUMBER 11, October 12 2019

Informing, alerting and empowering NHS staff and campaigners

RCP warns of vacancies

Private GP service sets sights on further NHS expansion

Paul Evans

Babylon health plans to expand its virtual GP service to Manchester after its reported success in attracting NHS patients to use its GP at Hand business.

The private company, which offers fast GP appointments by video has attracted over 60,000 NHS patients in Birmingham and London and if its plan is accepted will be up and running in Manchester by early 2020.

The CCG backed the expansion to three major cities, under current regulations patients who sign-up for GP at Hand are all registered with Babylon Health's GP practice in Hammersmith & Fulham in West London; so it's this CCG that will be required to give approval for the expansion to Manchester.

Problems for CCG

Babylon's expansion in this way has led to major financial problems for Hammersmith and Fulham CCG as it is responsible for thousands of new patients registered on GP at Hand whether they live in their area or not.

The CCG eventually gave approval for the expansion to Birmingham, with the proviso that no more than 2,600 patients be registered in the area in the first three months.

However, changes announced in late September by NHS England and NHS

The app will see you now ...

New contracts for 'digital-first' GP providers will probably require them to set up a physical clinic in the area

Improvement will change this and have a significant effect on the way Babylon Health operates from June 2020 onwards when they come into force.

The new contracts will remove patient registration and mean that once 1,000 patients are registered in a CCG area by a provider outside this area, then the provider will be issued with a new APMS contract covering that area.

Financial burden

This means the patient list is divided up and no single CCG bears the financial burden of thousands of extra patients registering.

GP at Hand has approximately 60,000 patients living outside Hammersmith and Fulham, and these patients will now have to be divided into 17 different lists in areas where GP at Hand has more than 1,000 patients.

Other changes mean that in the areas where the new contracts are issued to the digital-first GP providers they will probably be required to set up a physical clinic in the area.

There is also a proposal that new digital primary care providers should be required to set up in areas lacking doctors and primary care access is poor.

Figures obtained by GPonline suggest that more than one in four NHS patients who registered with Babylon GP at Hand quit the video consultation service within just over a year.

A successful Mental Health Summit on September 28 organised by campaigners including Keep Our NHS Public and Health Campaigns Together has now published video and reports as part of a drive for more concerted campaigning.

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https://lowdownnhs.info/ contactus@lowdownnhs.info

We have had some success, and thank those individuals and organisations who have donated.

But seven months on, we need to step up our efforts to raise enough money to take us unto and through a second year, enough for us to be able to reach out and offer work to freelance journalists and, designers.

This autumn we will be making a fresh appeal to trade union branches, regions and national bodies – but also to individual readers.

We are providing this information free to all -- but it is far from free to produce.

If you want up to date information, backed up by hard evidence, that helps campaign in defence of the NHS and strengthens the hand of union negotiators, please help us fund it.

We urge those who can do to send us a one-off donation or take out a standing order.

More details of this and suggested contributions are in the box below.

Our commitment is to do all we can to ensure this new resource remains freely available to campaigners and activists.

Without your support this will not be possible.

Help us keep The Lowdown running in 2020

We really want to run this publication without clumsy paywalls that would exclude many activists – but if we are to develop new expertise we do need to recruit staff, and so we need the resources to pay them.

We have therefore always planned to fund the publication through donations from supporting organisations and individuals.

We urge union branches to send us a donation … but also please propose to your regional and national committees that they invite one of our editors to speak about the project and appeal for wider support.

We know from our surveys that many readers are willing to make a contribution, but have not yet done so. We are now asking those who can to give as much as you can afford. We would 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 will be able to choose how, and how often to receive information, and are welcome to share it far and wide.

On the website we will gratefully acknowledge all of the founding donations that enable us to keep this project going into a second year.

- Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG
- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at *contactus@lowdownnhs.info*