The lowdown

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

NHS and social care need better plan to cope with demand for care

For the first time more than 50% of NHS patients referred for hip and knee replacement are being treated in the private sector. This care is funded by the NHS, but spotlights a growing reliance on the private sector and the failure to build sustainable NHS capacity.

Meanwhile in the care home sector we see the price of such dependence where eight out of ten are run for profit, but many are now closing, pushed under by Covid shocks and the previous funding squeeze.

It is adding to the pressure on NHS hospitals, as patients are stranded unable to be discharged from hospital beds because of a lack of care home places.

The fate of the health sector – still mostly publicly run – and the largely private care sector are locked together, both in peril, for lack of public funding and action around securing enough health and care workers.

For the public, long waits and the impression of a worsening NHS are now leading to increasing numbers of better-off patients opting to pay for their own private care.

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Public confidence in the NHS is taking a knock.

Ministers blame the reverberations of the pandemic, they are silent on the origins of the problem and talk up the future. Back in the real world there is a growing sense of jeopardy, and acknowledgement that both sectors still lack the workable plan they need to respond to the crisis that consumes them. Ministers have a further chance to act in the Comprehensive Spending Review due at the end of October.

A stack of think tank reports chime on the previous failures of policy. Too often investment has been too slow and when it arrives insufficient. The latest increase for the NHS will help across the next two years according to the IFS, but not for the medium term and is certainly no solution for social care.

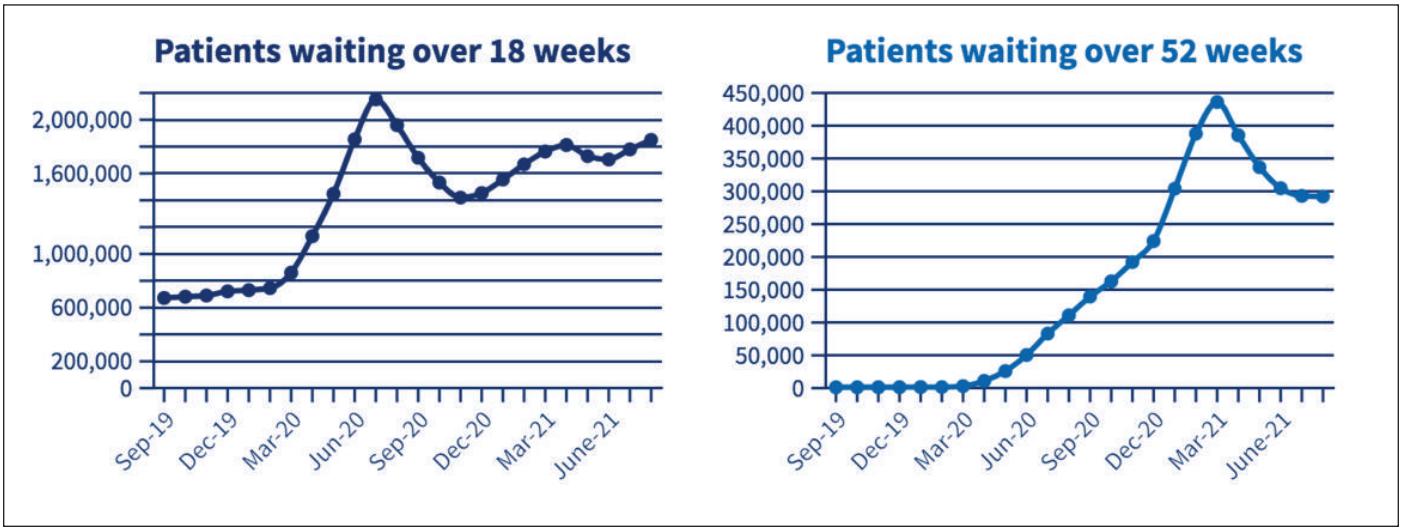
The government is still not getting the message even though the latest shocking workforce estimates suggest that the health and social care sector need to recruit over a million extra staff before the end of the decade, an intimidating task given the government failure to recruit 6000 extra GPs, in fact numbers have barely increased.

In England the NHS has a workforce plan, which true to form has been hampered by delays in funding, but these plans do not stretch to anything like the change in capacity building suggested by these Health Foundation estimates. Advances in areas like digital health can help but won't be enough.

The alternative path that the government seems more likely to follow is to continue to underfund, or at best pursue a just-in-time funding policy, leading to insufficient staffing growth. Concurrently they are pursuing the old habit of encouraging further reliance on the private sector to bolster NHS capacity.

In mental health - where 44% of the child and adolescent mental health budget is spent with private providers, in diagnostics and in parts of community health, the private sector has become central to the delivery of mainstream clinical services. These companies have growing control, and often despite damning criticism of their performance.

The adversity of Covid has fast tracked some outsourcing, and supplied the justification too. The network of NHS labs was bypassed in favour of partnerships led by the private sector, and the pandemic had barely receded before ministers announced that this policy was to be further expanded.



Incidentally, it was confirmed in a new analysis this week that private hospitals who took an estimated £400 million a month in payments to provide access to 8000 beds at the start of the pandemic had infact very few NHS patients to occupy them. And now that long NHS waiting lists are driving up demand for private care, companies appear less keen to help out with NHS patients.

This shines a light on the reality that the NHS and the private sector don't share the same core interests. It is unlikely that private hospitals will use the £10bn opportunity the government has created for them to perform surgery on NHS patients, as they can earn more from their private patients. For-profit companies also tend not to seek NHS contracts to provide care to the poorest communities, despite their greater need.

So failure to invest in growing NHS capacity, in NHS staff and buildings, will inevitably mean letting the private sector have greater control in our NHS, and will challenge the delivery of comprehensive care to all of us, leave huge inequalities in the service in place and do little on the prevention of sickness. Where is the tipping point? We will explore that in a future article.

Paul Evans

Watford's £900m plan for 'pie in the sky'

West Hertfordshire Hospitals Trust is one of the original six "pathfinder" schemes promised priority funding ahead of the pack as part of Boris Johnson's election pledge to build "40 new hospitals".

But like the other "pathfinders", not a brick has been laid: the West Herts project has remained stuck in a limbo of denial of the likely cost, and dispute over the plans – not least where the new hospital should be built.

Campaigners from the New Hospital Campaign (NHC) have consistently argued that rebuilding on the existing Watford General site – right next to Watford football ground – would result in delays, constrain the size of the new hospital, inflate the cost, and deliver a centre that would be hard to get to from St Albans and Hemel Hempstead – and especially hard to reach by public transport.

They argue that the Watford site has remained the preferred option, despite Watford having a population of only 100,000, only because the Trust back in 2005 signed a 'memorandum of understanding' tying it in to a legally binding agreement with Watford Council and commercial Health Campus Partners. This included a commitment to contractual agreements for "disposal of surplus land."

The proportion of "surplus" land has grown as plans to build housing on the so-called Health Campus have become more ambitious, now standing at up to 1,000 'residential units:' under the design produced by the Trust the hospital would take up 3.67 hectares, half the current hospital 'footprint'.

Hospital or housing?

So large have the non-health elements of the project grown that in 2017 Watford Borough Council agreed the name Health Campus should be changed as it "had implied something to do with the hospital exclusively whereas the site would have a mixed use with a high proportion of residential and business development." The name Riverwell was adopted "to reflect the importance of the river and link to neighbourhoods such as Holywell and Brightwell."

Campaigners point out that as of October 2021, "the Trust's website was extraordinarily carrying a link to the Watford Riverwell website, a marketing site for apartments."

Meanwhile the projected scope of the hospital has been increased to 1,000 beds – leaving the only option as building upwards on the available land, to produce three tower blocks of up to 18 storeys – and a sky high cost, which campaigners, backed by Hemel Hempstead Tory MP Sir Mike Penning now warn is likely to exceed £900 million.

The campaigners argue that this estimate leaves out any non-construction costs including inflation on the equipment to be used to fit out the buildings, and inevitable extra unknown costs from building on a sloping, difficult site with some parts at high risk of surface water flooding.

But while West Herts plans head towards double the initial projection of £540m to rebuild Watford Hospital, the financial brakes have come on at national level.

Pathfinder schemes have been called on by NHS England's New Hospital Programme to submit plans limiting the cost of each development to just £400m – less than half the likely Watford cost – and campaigners warn the delays already make it unlikely that any significant new build could be completed until 2028.

Concerns are also being raised by campaigners in Hemel Hempstead over the reduction of their former hospital into a clinic, quite possibly with no beds at all, and large parts of the building boarded up. They warn that a similar fate could also be in store for St Albans if acute care is increasingly concentrated on the Watford site.

But at the current rate of progress there will be many more years of arguments before any real change occurs.

John Lister

Javid focuses on pharmacies to help with GPs' workload

Big on presentation and short on detail, health secretary Sajid Javid's roll-out of the £250m 'winter access fund' last week nevertheless gave the clearest indication yet of the government's strategy to solve the crisis in primary care: coerce and mislead, and talk up pharmacies instead.

As the primary care sector struggles with a shortfall of 6,000 GPs and 26,000 nurses and receptionists, the government's response – outlined in the NHS document 'Our plan for improving access for patients and supporting general practice' – is a £250m 'winter access fund', worth just £33,000 per surgery.

Sold to the public as a way to "help patients with urgent care needs to get seen when they need to, on the same day, taking account of their preferences" – in effect mimicking the sales pitch of a telehealth service – the awarding of this cash, however, requires primary care networks (PCNs) to use the NHS Community Pharmacist Consultation Service (CPCS), overseen by the independent Pharmaceutical Services Negotiating Committee (PSNC).

The strategy also suggests that pharmacists joining up with PCNs will now "automatically be trained to prescribe", adding that NHS England is continuing "to increase the role of community pharmacists in delivering appropriate services". The move was reported in the Daily Mail as being "likely to include handing [pharmacists] the power to prescribe a number of medicines which are currently the sole preserve of doctors".

This gives the misleading impression that pharmacists have up until now been unable to prescribe. But they can, and have been doing so since 2006.

Guidance from government agency the National Institute for Health Research suggests pharmacists – along with nurses, midwives, dentists, optometrists, podiatrists, physiotherapists and therapeutic radiographers – can already become 'independent prescribers', meaning they can prescribe any drug within their competency, including controlled drugs.

Documentation supporting the health secretary's strategy, meanwhile, also includes plans to "embed electronic fit notes in hospital systems", with the Mail apparently suggesting that hospital doctors writing more prescriptions is part of the new bargain too. But the implied suggestion that hospital doctors

don't already do much prescription writing is again misleading.

As NHS hospital consultant Dr David Oliver told The Lowdown last week, "The standard NHS contract with providers already makes it clear that hospital doctors should do sick notes and prescriptions, and also follow up on test results. This is all in the public domain and negotiated between NHS England, the BMA and other key organisations – and this has been the case for a good while now."

Continuing his push to promote the role of pharmacies, the health secretary also mooted the idea of a national version of the Pharmacy First marketing programme, currently being piloted by local CCGs across England.

Pushing for a bigger role

Such a move would certainly help boost the profile of the sector, but there are other behind-the-scenes initiatives in the pipeline aiming to further embed pharmacies within the NHS.

The PSNC is currently lobbying for pharmacy representation on the NHS' new Integrated Care Boards, alongside GPs. It has also reported that the £250m winter access fund is not going directly to GP practices but is being distributed via local CCGs, noting an opportunity to bid for funding on behalf of the sector.

Meanwhile, last month (September) the All-Party Parliamentary Pharmacy Group (APPG) launched an inquiry, supported by the PSNC, into the future of pharmacy in the wake of the pandemic. It is seeking views from the pharmacy sector on a range of issues, including "how pharmacy can be better integrated into NHS care pathways".

Pharmacies undoubtedly play a useful role in public health programmes. High street chains Boots, Lloyds, Superdrug and Well are all notably taking part in the current flu vaccination campaign, and at the time of writing Boots and Lloyds were also involved in the covid booster jab programme.

But, at the same time, pharmacies have done very well out of a public health crisis. Accountancy group UHY Hacker Young has noted that the number of mergers and acquisitions deals in the UK pharmacy sector has risen 26 per cent in the last year, thanks largely to pharmacies being one of few sectors to benefit from increased customer demand during the pandemic. It also noted private equity buyers were showing increased interest in the sector, with the US owner of Lloyds Pharmacy, McKesson Corporation, having recently been in talks with three prospective bidders for the sale of its UK business.

The pandemic has certainly provided a boost to retail pharmacy chains' ventures in the telehealth sector – such as Lloyds Pharmacy's Video GP and Boots' recently launched Online Doctor services, both able to issue prescriptions – just as cash- and resource- starved GP surgeries continue to struggle. Boots has said it is looking to further expand its online services soon, starting with mental health.

In a parallel bricks-and-mortar move by the retailer, the Sun reported earlier this month that Boots is to offer £15 GP-style health face-to-face appointments for minor ailments. The company's chief executive Seb James told the newspaper, "Rather than wait two weeks to see a GP, people can [now] get immediate diagnosis, treatment and medication for the price of a Nando's."

US influence

An indication of where Boots might be heading in the UK with its pharmacy operations can be gleaned from the latest move of its US owner Walgreens Boots Alliance (WBA). This month WBA spent $5.2bn on increasing its stake in primary care network VillageMD to 63 percent, in the process becoming the first pharmacy chain in the US to offer full-service primary care practices with physicians and pharmacists co-located in its retail outlets.

However, some elements of US culture don't always sit well in a UK context. In 2017 Boots was criticised after telling the British Pregnancy Advisory Service (BPAS) it was simply avoiding "incentivising inappropriate use" by refusing to reduce the cost of its Levonelle emergency morning-after pills. And earlier this year BBC News noted cases where individual pharmacists have refused to give out the morning-after pill because of their religious beliefs.

How developments like these play out long term remains to be seen, but those assuming general practice will remain the bedrock of the NHS could be in for a shock, as pharmacies – which are as much profit-driven enterprises as they are community services – gradually assume the role of primary care provision while subtly undermining the concept of 'free at the point of access'.

An enhanced ability for pharmacists to write as well as dispense prescriptions, alongside the new obligation for GPs to, in effect, push business their way at the same time – as Javid is proposing – will undoubtedly prove a nice little earner for pharmacies. It could also encourage more US retailers to consider entering the UK market, in much the same way as Centene Corporation and Operose Health saw value in buying London primary care service provider AT Medics earlier this year.

But Javid's CPCS initiative interestingly coincides with a proposal by the Department of Health & Social Care (DHSC), which he oversees, to scrap free prescription charges for people aged between 60 and 66. This move, seen by some as representing a "tax on the sick", could adversely affect the health of more than two million UK citizens if implemented, according to Age UK and the DHSC's own impact assessment. Then again, it could also drive others affected by the move to consider signing up to services like Boots' Online Doctor and Lloyds' VideoGP..

Martin Shelley

Care worker shortage will increase NHS waiting lists

The social care sector is facing a crisis in staffing, with an estimated 105,000 vacancies, according to the 2021 State of the Adult Social Care Sector and Workforce report by Skills for Care, and with the possibility of this rising sharply as the requirement to be double vaccinated to work in a care home comes into place in early November.

The staffing crisis means care homes are having to refuse to take new arrivals discharged from hospital and companies that provide care within the home are handing back contracts as they no longer have sufficient staff.

The knock-on effect of this is that the NHS will really struggle to make any inroads on the record 5.74 million waiting list, particularly as winter bites with its associated increase in patients.

The Guardian reported that Britain's largest not-for-profit care home provider, MHA, has already had to close one in 10 of its homes to admissions from hospitals.

Around 78% of providers of home care who responded to a survey carried out by ITV and the UK Homecare Association in September 2021, said recruiting carers is the hardest it has ever been. Many described the situation as being at "breaking point".

The shortage of staff means that around 30% of the 843 providers surveyed were handing back some, or all, of their care to local authorities because they can no longer fulfill their contracts, and 95% said they are unable to take on all the new clients in need of their help.

Other surveys in the past few months by the National Care Forum and the Institute of Health and Social Care Management highlight the staffing crisis, with eight out of ten operators saying levels of service are under threat, with some capping resident numbers and companies declining care requests due to lack of staff.

Unsustainable pressures

What this means at the grass-roots level is that vulnerable patients are going without the care they need to live at home, basic help with getting up, dressed and fed, families are waiting months for care packages to be put in place, and patients that no longer need hospital care can not leave but are stuck taking up beds space that could be used by one of the 5.74 million on the waiting list for surgery.

What this means for the staff still working is that many are having to regularly work 60 hours a week, or more if they are required to be on-call. Such long hours are not sustainable, but as the

shortage of care workers increases, they are going to become more and more likely, with the resulting increased loss of staff.

Staffing was an issue before the pandemic, with an estimated 100,000 vacancies, but Brexit and the pandemic has turned the staffing issue into a crisis.

Burnout during the pandemic has led care workers to reassess their lives, aggressive recruitment from other sectors, such as Amazon and the hospitality sector, where care workers are able to earn much more, and the change in immigration rules as a result of Brexit - have all led to the current crisis and continue to fuel the loss in staff and the difficulty in recruiting new people.

Jabs and low pay disincentives

In addition, the deadline for mandatory double vaccination for all care workers to be able to work in care homes in early November, is looming and there are still many workers that have not been double vaccinated. There are reports that many have already left because of this requirement and if the remainder are not double vaccinated then they will have to be deployed out of the care homes to the home care sector.

A recent NHS England figure was that 88% of staff in care homes for older adults had been vaccinated by 14th October, leaving 12% or 55,600 workers needing either the second dose or both doses. Unless they are vaccinated soon they will either leave the care sector or have to be redeployed to a care at home service.

Back in early September, a care home manager told the Guardian that Amazon's new warehouse in Nottinghamshire was luring staff with 30% more pay.

An evening housekeeper at the care home on £9.30 an hour left to take a job picking orders in the Amazon warehouse on £13.50 an hour. The retailer is also offering a £1,000 joining bonus. The care home had also lost six to better-paid jobs in the NHS and four who left due to the introduction of the vaccine as mandatory.

Pay has been an issue in the care sector for many years, now as vacancies rise in other sectors, why would you stay in the care sector when in many cases workers are being paid below the National Living Wage. In July 2021 an investigation by ITV, the Bureau of Investigative Journalism (TBIJ) and the Mirror found that many home care workers are still paid below the Real Living Wage (RLW), even though dozens of councils have pledged to pay at least that rate.

The investigation found 60% of all home care jobs advertised in the previous six months offered a wage which would not be enough to live on.

This was more than 7,000 advertised jobs offering less than the RLW of £9.50 an hour in the UK and £10.85 in London. In Wales, the investigation found 75% of care work ads offering below the RLW.

The Skills for Care report shows that Brexit and new immigration rules have compounded the workforce shortage with a fall in foreign staff coming to fill vacancies. Less than 2% of new starters in the first quarter of this year arrived from abroad, compared with more than 8% in 2019, a drop of about 20,000 people.

The new immigration rules from 1 January 2021 mean that it is almost impossible to recruit from abroad. The salary of a 'care worker' does not meet the required threshold. The only way to recruit would be if 'care worker' is added to the Shortage Occupation List (SOL), an official list of roles for which the domestic labour market cannot meet the demand to fill vacant posts.

Back in March 2021, the government u-turned and agreed to add 'senior care worker' to the SOL, after initially refusing to add the job, but it has consistently refused to add any other care worker job titles despite lobbying by the industry.

Care England, which represents the largest private care home chains, said ministers should cut the qualifying salary level for overseas recruitment of social care staff from £25,600 and add all care workers to the shortage occupation list used to grant visas.

NI rise will have an impact

And on top of all of this the increase in National Insurance announced by the government back in September will place an additional strain on recruitment, according Pete Calveley, CEO of Barchester, the UK's second-largest private care home operator. He said the tax rise will cost his 17,000 staff about £6m a year and his company around the same amount. He told the Guardian:

"At a time when it is very difficult to recruit staff into social care we have less money to increase their salaries. It is just utter madness and I can't believe this is what they have done."

So what is the government doing to address the issue? Well when it is asked to comment the Department of Health and Social Care talks of running regular recruitment campaigns, encouraging staff to get vaccinated, and wanting employers to make long-term investments in staff rather than recruit from abroad, plus of course that £500m to support the care workforce. And that is it!

NHS England meanwhile has told hospitals to stabilise the number of patients waiting for hospital treatment, keep people waiting over a year for surgery at current levels, and eliminate two-year waits by March 2022.

However it's clear that NHS England can set whatever targets it likes, but it will be impossible to achieve them if patients cannot be discharged to social care services and therefore the crisis in social care staffing needs to be addressed with some urgency. If this doesn't happen, then waiting lists will rise and more and more vulnerable people will not get the care they should.

Sylvia Davidson

The privatisation of social care

COMMENT: The growing crisis in social care in England, and to some extent in the rest of the UK, can be seen as largely the result of government policies.

The current dysfunctional social care system itself, dating back to the 1993 separation of long-term care from the NHS where it was free at point of use, and its transfer to local government, where it has been largely privatised and subjected to means-tested charges, flows from decisions by the Thatcher government and 1988 advice from Sainsbury boss Sir Roy Griffiths.

New Labour pulled back from Royal Commission recommendations to reform this system. And since 2010 over a decade of austerity has brought real terms cuts in social care spending and local authority budgets, widening inequalities in health and circumstances between rich and poor, and social care staffing problems exacerbated further by post-Brexit tightening of limits on immigration. Numbers of non-British staff seem certain to decrease.

Staff shortages in social care have now reached a new peak of 105,000 vacant posts, leading some care homes to close their doors to NHS patients who should be discharged from hospital beds. With high levels of turnover as staff leave for better jobs elsewhere, and three quarters of front-line care staff earning below the living wage of £9.50 per hour, it's unlikely that any surge of new recruitment will fill these gaps.

Instead up to 59,000 staff (13% of those working in older adult care homes) seem set to leave or lose their jobs as a result of not being double vaccinated by 3 October, after ministers insisted double vaccination had to be a "condition of deployment" in care homes in England from 11 November.

In September health secretary Sajid Javid announced an extra £478m would be allocated to fund "discharge to assess" schemes in England for another six months – money which is now being described as support for social care. But the big announcement of £36 billion to be raised for the NHS and social care over the next three years from increase National Insurance payments included just £5.4bn (£1.8bn per year) for social care, beginning next April, and running up to 2024.

The National Audit Office warned earlier this year that the total cost of care is projected to rise by 90% for adults aged 18 to 64, and 106% for adults aged 65 and over was due to double in 20 years from £28bn to £55bn per year.

The NAO report also noted that local authority spending on care reached its highest ever cash level in 2019-20, at £16.5bn, but this was 4% lower in real terms than in 2010-11. Since 2015-16, the number of adults aged 65 and over receiving long-term support arranged by local authorities has fallen, and almost a quarter (24%) have unmet care needs.

And of course 'Baldrick' Johnson's infamous 2019 claim to have a cunning plan ready to sort out social care has proved time and again to be as worthless as his promise of an "oven-ready" Brexit. But while many of the problems of social care have been inflicted by ministers, new studies of social care systems in the EU remind us that many EU governments facing similar problems have found different ways and chosen different priorities.

Both reports focus on long term care of the elderly, whereas we know that in England social care is viewed more widely: 'adult social care' covers social work, personal care and practical support for adults with a physical disability, a learning disability, or physical or mental illness, as well as support for their carers. Roughly a third of adults receiving social care in England are aged 18-64, two thirds are older, and the EU's Social Protection Committee points out that "the great majority of the recipients of long-term care are older people."

The European Social Network (ESN) study Putting Quality First, Contracting for Long term Care begins with the differences between the systems in the 27 EU countries, noting that public expenditure on Long Term Care (LTC) ranges from "small budget lines within social assistance schemes, as in many Eastern European countries" to spending of over 3% of GDP in the Netherlands or Sweden. Current UK spending (£28bn) is around 1.3% of GDP.

But there are also big variations in the extent to which services and facilities are delivered by public, private not-for-profit or for-profit providers: "While in the UK and Germany the share of private providers is comparatively high, the Nordic countries are still characterised by extended public service provision."

The British government of course has never respected, and now broken from the European Pillar of Social Rights, Principle 18 of which states: "everyone has the right to affordable long-term care services of good quality, in particular homecare and community-based services."

And while few in Britain would even have been aware that this commitment existed, England can be found to be drifting further away from the mainstream acceptance in most of the rest of Europe that the need to support older people is more important than guaranteeing the profits of private care home bosses and domiciliary care companies.

Some systems are much more proactive than others in supporting informal carers: Sweden, Germany and Austria in particular have invested in specific services to support informal carers, Spain pays them an allowance and contributes to their pensions: Finland and Slovenia offer informal carers training courses.

By contrast few steps have been taken to implement promises in England of more support for carers.

However the British drive towards privatisation, competitive tendering and marketisation of social care has become the norm even in systems that are much more generous than in England. The ESN report notes: "With the dissemination of New Public Management principles [purchaser/provider split, compulsory competitive tendering, contracting and performance management] … over the past three decades, practices of procurement, commissioning, purchasing and contracting have entered public service provision and governance in Europe, though with rather different meanings, scope and impact."

The common assumption, as in Britain was that competition would both increase efficiency and reduce prices: but price competition can lead to a race to the bottom in qua——+ ≠ ≠lity of care, especially if there is not strict monitoring of contracts and precise specification of services. Nonetheless:

"Over recent decades, most countries in Europe have seen an increase of private provision and promoted access to new (private) providers due to explicit national policies that introduced New Public Management approaches and compliance with EU market rules. Purchaser-provider splits, compulsory competitive tendering and abandoning of traditional subsidised funding led to the establishment of 'long-term care markets'."

The focus of the ESN study is not to challenge these new markets, but on trying to improve quality within them. It notes that contracting individual services "is not sufficient to ensure seamless LTC". While in theory public authorities could seek to commission and coordinate the services of several providers, "we do not yet have examples of such practice."

Instead ESN suggests a different, more complex approach, already in use in the Netherlands:

"rather than paying for or reimbursing individual services (based on the number of places/beds/clients, or by the number of hours or days), integrated LTC delivery could also be purchased as a 'bundle of services' based on defined outcome(s), such as reduced hospital admissions …"

The study also looks at, but appears unconvinced by personal budgets for individuals to buy their own social care, noting from the outset that they are linked to needs assessments "to work out the type of care and support the person needs, how much it would cost, and how much they may be able to afford themselves."

The ESN does acknowledge that EU law allows governments to exclude as much of social care as they wish from procurement law, allowing them to retain it with the public sector: but it also notes and does not challenge the fact that "a fundamental aim of the EU is to create a common market based on competition, equal treatment and transparency …"

So the main focus is on seeking ways to best regulate and manage the private sector to increase quality. One obvious problem is that competitive markets are themselves unstable: larger companies tend to deal with smaller ones by taking them over or forcing them out of business. In Finland for example:

"In long-term care, there has been a huge increase of private for-profit provision during the last 15 years. At the same time, the number of private companies as providers has decreased dramatically. Instead, three to four large companies have taken over most of the market (…)."

The largest share of private providers is in Ireland and the UK, while in residential care the share of private for-profit companies ranged from 1% in Croatia to 80% in Ireland. The average in LTC as a whole is a market share of 42% for the public sector, 36% for-profit and 22% non-profit.

But the reliance on a competitive market has its on-costs, with respondents to an ESN questionnaire flagging up their greatest concerns as bureaucracy in tendering (63%); quality of care (59%); rising prices (44%); and continuity of provision (30%). Among the challenges in procurement from the market the ESN notes a problem that is now increasingly obvious in England:

"Procurement processes also lead to unsustainably low prices, which have detrimental effects on terms and conditions for staff and ultimately lead to workforce shortages, which limit supply."

It also notes "Tenders do not always guarantee the choice of the best organisation in terms of reliability and ethical principles." Furthermore: "it has become evident that strategies of pure cost reduction resulted in unsustainable conditions of service provision."

A second report, The 2021 Long-Term Care Report: Trends, challenges and opportunities in an ageing society, commissioned from consultants KPMG by the EU aims to "increase understand-

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NHS given set ‘guidance’ as NHS England sides with ministers

C/Tim Hammond/No 10 Downing Street

“The floggings will continue until morale improves.” That’s clearly the way management is viewed in today’s crisis-ridden NHS. It seems set to drive away yet more vital staff from front line posts as they see no sign of support from senior management.

Life for NHS management was stressful enough before NHS England’s new boss Amanda Pritchard opted to throw in her lot with the scurrilous Daily Mail, welcoming their vicious campaign to vilify “lazy” “overpaid” GPs as offering 'a strong voice for patients' and “highlighting the devastating decline in the number of patients able to see their doctor in person.”

The supine willingness of NHS England’s chief executive to slavishly endorse Sajid Javid’s so-called package of ‘support’ for GPs that amounts to just £30,000 per practice, but also includes counter-productive and ill-informed plans to ‘name and shame’ surgeries failing to deliver enough face-to-face appointments and the threat to send in 'hit squads' and impose cash penalties on surgeries that “refuse” to see more patients in person makes it clear as day that she would just as happily throw trust bosses under the bus next, if the going gets tough.

Ms Pritchard’s cynicism in joining in the right wing jamboree of abuse against GPs (endorsed in the Mail by two obscurely-funded right wing “think tanks,” the so-called ‘Tax Payers Alliance’ that resents every pound spent on public services and the Institute for Economic Affairs which wants to replace the NHS with an insurance system) is underlined when we look at the proposals for primary care set out by Pritchard and NHS England in Operational Planning Guidance on September 30.

This asks “systems” to: “support practices with access challenges so that all practices are delivering appropriate pre-pandemic appointment levels, including face-to-face care as part of a blended access model.”

NHS England doesn’t mention the fact that in June 2021 GPs delivered 3.5 million (15%) more consultations than in June 2019 before the pandemic; or that the reason for the increase is 6m additional telephone consultations per month than 2019 – in line with NHS England’s own Long Term Plan and its agenda of “digital first”. Without the use of telephone triage to deal swiftly with easier cases and select the patients who need face to face consultations, the number of consultations is likely to go down significantly.

The Guidance promises “shortly” to set out details of continued investment to support general practice capacity and improve access – which turns out to be Javid’s £250m package of reallocated funds, with strings.

But the Guidance specifically stressed the importance of telephone and online consultations:

“Building on the successful deployment of remote consultation systems during the pandemic, systems are asked to continue to support PCNs and practices to optimise the use of these technologies, including by funding advanced telephony, to improve experience for patients and practice staff.”

So the message is clear for NHS management: stick to NHS England’s own guidance and you will be shafted as soon as

anything goes wrong. The entire Guidance document is an exercise in denial, impossible demands and empty platitudes about "supporting the health and wellbeing of staff".

The promise on waiting lists, which have now passed 5.7m as they continue to increase, is a demand that NHS management "maximise elective activity and eliminate waits of over 104 weeks (2 years)" by March 2022: "The aim is to return to – or exceed – pre-pandemic levels of activity across the second half of the year …"

But NHS England must be aware that most acute trusts are well short of pre-pandemic capacity, with thousands of beds still closed, thousands more occupied by Covid patients, and thousands more again unoccupied either for infection control or because staff have been diverted to Covid work. The Guidance is largely silent on how trusts lacking beds, staff, revenue and capital are supposed to haul themselves back to previous levels of activity.

Delaying by 'advice and guidance'

They are asked to "work closely with independent sector (IS) providers": but many of these private hospitals are finding lucrative work from self-pay patients seeking to escape long delays on NHS waiting lists, and will be less and less interested in taking NHS-funded patients at lower rates.

The guidance also suggests that one in eight outpatient referrals should be delayed by use of "advice and guidance requests" and all systems are asked to show how they are cutting back on referrals "with assessments to monitor the impact on avoiding referrals" (p7).

And while Pritchard has ignored BMA warnings, and joined the hue and cry over GP face to face consultations, the Guidance required hospital doctors to "continue to grow remote outpatient attendances where clinically appropriate with an overall share of at least 25%," and "consider options for digital-first elective care pathways that reduce demand …" (p8)

NHS England also makes clear that extra funding will only be available to the trusts that are already coping best with demand – and least in need of it: "systems that achieve completed RTT pathway activity above a 2019/20 threshold of 89% will be able to draw down from the Elective Recovery Fund." Some of this money will be available to fund private hospital treatment, but not to assist struggling NHS trusts. (p8)

On cancer care, the Guidance admits "diagnostic and treatment volumes are not keeping up with restored levels of demand at a national level, meaning more patients are waiting longer." But it offers no extra resources, just a requirement to "return the number of people waiting for longer than 62 days to the level that we saw in February last year (based on the overall national average) by March 2022." (p9)

On mental health, too, NHS England notes briefly the mismatch between demand and resources:

"We estimate at least 1.5 million people have been accepted for / are eligible for care but are yet to receive it." (p10)

But the 'Guidance' offers only a series of impossible demands, requiring trusts to "accelerate" the recovery of face-to-face care in community mental health services; reduce out-of-area placements, long lengths of stay and long waits in EDs for mental health patients and – not even pretending that these are NHS provided services – "continuing to increase access to "children and young people's NHS-funded community mental health services" and "NHS-funded talking therapies".

The complete insensitivity of NHS England to the rising tide of scandals besetting maternity services up and down the country, and their indifference to the safety issues arising from the lack of qualified staff is indicated as the Guidance adds:

"Systems are asked to continue to prioritise action to make maternity care safer and more personalised."

And, as the Health and Care Bill plans to strip away the legal right of vulnerable patients to have their needs assessed before being discharged from hospital, NHS England makes clear that from March next year there will be no central funding to support so-called "discharge to assess" schemes, and stresses that: "Systems should plan to implement hospital discharge arrangements that are sustainable and affordable from core NHS and local authority expenditure into April 2022."

Waving a magic wand?

Oh, and somehow from existing staff and resources "Two-hour community crisis response teams are expected to be providing consistent national cover (8am-8pm, seven days a week) by April 2022 across every ICS." (p12)

The final show of denial is in the Guidance on urgent and emergency care, which notes "sustained pressure" but simply demands trust bosses wave a magic wand to: "reduce the number and duration of ambulance to hospital handover delays …" and "eliminate 12-hour waits in EDs."

Systems are asked to develop effective integrated operational delivery plans" which "must ensure that there are robust and effective assurance and escalation processes to rapidly identify and mitigate against bottlenecks and risks from across the system."

We can expect any manager that fails to be ruthlessly pilloried by the right wing press and ministers, with Amanda Pritchard joining in. It's shameful, but it's today's senior management refusing to speak truth to power… and preferring to join in the bullying and abuse of hard pressed staff on the front line.

John Lister

...continued from page 9

ing of long-term care supply structures in member states".

It also points to the increase over 30 years in market-based and private provision and that among the common features across the EU has been a growing focus on home care and services to support people living at home, and the fact that while policies are shaped nationally, control of social care tends to be local. Most long-term care providers are also based in the country itself, while the few multinational providers are mostly for-profit corporations.

The KPMG report analyses four main trends in reforms in social care: measures to improve the situation of informal carers (in 15/27 EU states, most notably in Poland, Austria, Czech Republic and Germany which have introduced or increased cash payments); improving access to and affordability of home care (in 16/27 EU states); improving access, affordability and quality of residential care (in 18/27 EU states); and improving the situation of the professional long-term care workforce with increased salaries, improved training and working conditions (10/27).

A summary of recent reforms (from page 104) goes on to look at steps to coordinate or integrate health care and social care, noting a major reform in Bulgaria, the 2018 decision in Greece to establish 150 'integrated care centres for older people,' and projects in Belgium and the Netherlands.

Reforms to improve quality of care have been implemented in Bulgaria and Finland, and the Netherlands has invested in "ambitious plans for improving the quality of residential care," with large-scale government investment.

Measures to improve the recruitment of social care staff include steps and spending to make care jobs more attractive in Sweden, Netherlands, Germany and Croatia. Salaries and conditions have been improved in Germany, Czech Republic and Netherlands, while Sweden has focused more on training and upskilling.

However KPMG notes there have been no reforms in the majority of members states with shortages of care professionals. The report would obviously have included the UK in this bracket had Brexit not occurred.

Measures that have been taken to support informal carers include a tightly regulated new carers' allowance in Portugal, paid leave for people taking time out from work to care for relatives (France, Slovakia, Czech Republic, Austria) and training (Bulgaria, Ireland, Finland).

KPMG's round-up points to more reforms for the sector that are coming, notably in France, Austria, Estonia and Slovakia, while Finland is also planning new 'health and social services centres.'

So while PM Johnson and his ministers dither and debate on how to address the social care conundrum, and face a service that has been dislocated, fragmented and privatised for over 20 years by ill-conceived market reforms, governments in other countries are already grasping the nettle and taking action in hopes of attracting the workforce they will need.

It's not hard to guess what the more attractive prospect might be for care workers: when there are countries that have improved pay, conditions and training – and are easily accessible through the EU's freedom of movement – why would they look to the UK where none of these is true, and things are getting visibly worse?

John Lister

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