The lowdown

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

Worst-ever crisis set to get worse

The elephant in the room during much of the interminable and vacuous "debates" between leadership contenders Liz Truss and Rishi Sunak competing for votes from Conservative Party members has been the dire state of the NHS after more than a decade of real terms cuts in bed numbers and funding, alongside increased pressures.

Truss's limited comments on the NHS were limited to a vague suggestion that she wants to "cut bureaucracy" – and slash £10 billion from NHS budgets to give to social care. This would amount to an impossible 7% outright cut in NHS spending on top of existing inflationary pressures and targets for £5bn "savings".

Calls for action

Outside the hermetically-sealed bubble of complacent and reactionary Conservative members there is near unanimity that the situation has gone from bad before the Covid pandemic to much, much worse.

Matthew Taylor, chief executive of the NHS Confederation, which represents trusts and commissioners, not known for hyping up an issue, has warned that the "NHS is in its worst state in living memory … There is no escaping that the NHS is in a state of crisis."

But funding is not the only pressure on the NHS. Earlier the NHS Confederation had breached convention by writing publicly to warn chancellor, Nadhim Zahawi that without urgent action to protect the living standards of the poorest against soaring energy bills the UK could face a "humanitarian crisis" of ill health, excess deaths and rising inequality this winter. Widespread poverty, cold homes and missed meals would inevitably push up rates of sickness, which could increase the number of winter deaths. Former Tory Health secretary Jeremy Hunt agrees:

"The new PM will inherit an NHS facing the most serious crisis in its history."

Alastair McLellan, editor of the Health Service Journal aimed at NHS management, told The Guardian: "There is not one area of NHS provision that isn't really struggling … There is literally nowhere where it isn't bad, and in some cases really bad."

Analysis in the Financial Times explains that the NHS is being "squeezed in a vice" – with too few beds and inadequate social care.

Recent Nuffield Trust analysis shows that the pandemic is by no means the only cause of the sky-high waiting list,

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which had doubled to 4.6 million between 2010 and February 2020.

"If pre-pandemic trends had continued, we might have expected the waiting list to be around 5.3 million."

The report concludes: "… it would be misleading to say that Covid is solely to blame for the crisis we now see in NHS services. Covid has accelerated the trajectory the NHS was already on, and makes the size of the NHS backlog less an unexpected aberration but rather a predictable consequence of the pandemic, for a system where pressures have been mounting for some time."

Even the Telegraph has admitted that in 2010 David Cameron's government took over an NHS that was "ticking along nicely" – but somehow glides over the fact that George Osborne's brutal austerity regime effectively began to reverse all of the previous investment.

Daily Mail graphs similarly show the disastrous decline in A&E and waiting list performance, cancer care, etc since 2010.

Deliberate underfunding

The Nuffield Trust's Sally Gainsbury has shot down the boasts by ministers that Rishi Sunak as Chancellor has given generous "record" funding to the NHS. Instead, she argues it faces a 3% real-terms budget cut (measured against whole-economy inflation figures for the budget in March).

This, she argues, is only "the first and widest step in a three-year plan to claw back the bulk of the extra funding given to the NHS to deal with the pandemic, with the following two years scheduled to see budgets grow at less than half the NHS's historic real-terms average.

"The upshot is that one of the first tasks for the 42 new integrated care boards now charged with managing the bulk of the NHS's budget is to deliver over £5.5 billion worth of spending cuts this year alone –"targeting savings" in NHS England's lexicon."

Nurses' and doctors' unions have focused on the long term worsening staffing crisis – which has been even more linked in to the hotly-disputed pay award as inflation has hit double figures and energy prices have soared. Staffing is vital to any expansion of services and patient safety: but the latest figures show 132,000 unfilled vacancies – a 25% increase in just 3 months – including 47,000 nurses and almost 11,000 doctors.

Dr Subramanian Narayanan, the president of HCSA, the hospital doctors' union, says the NHS is in a worse position to face a pandemic now than it was in 2020. "Staffing shortages are more severe than at the beginning of the pandemic and there is no evidence that the drivers of this are being addressed."

The situation is worsened further by constant sniping attacks by the right wing press apparently on a mission to vilify GPs, despite a reduced number of GPs delivering higher than pre-pandemic numbers of appointments, two thirds of them face to face. But now GP practices are also set to face losses of tens of thousands of pounds due to rising inflation and uncapped energy costs, according to Pulse, which could force some struggling practices to hand back their contracts, leaving patients without access to primary care.

And while the media focus tends to be fixed upon acute hospitals, mental health too is facing a triple whammy of inadequate capacity, especially bed numbers, inadequate staffing (with repeated broken ministerial promises of action) and rising demand – which has been worsened by the pandemic and now by the rapid collapse of living standards as the poorest are hit hardest by inflation.

Right wing sees opportunity

The problems are daunting, and as satisfaction ratings plunge, right wing politicians, columnists and pundits from a range of obscurely-funded right wing think tanks are hoping the public is feeling sufficiently disenchanted with the NHS to consider so called "reforms" and alternative models – which offer greater scope for private profit in health insurance and provision of services.

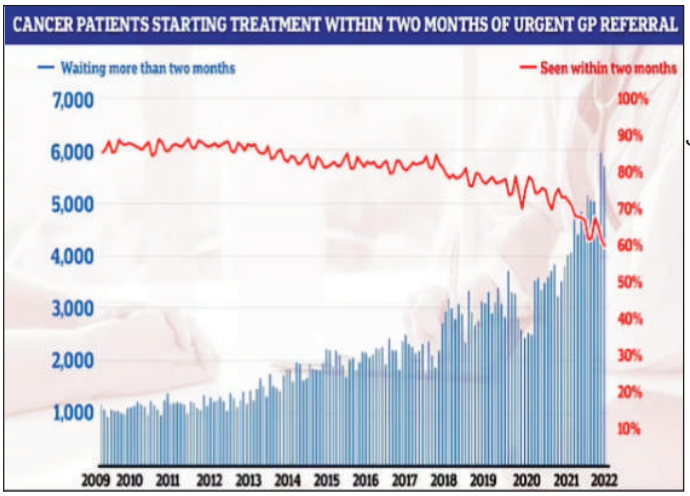
The BBC's Nick Triggle has now echoed and reinforced the right wing's defeatist line that it is "near impossible" to repair an NHS broken by the last decade of real terms cuts – despite the evidence of the 2000-2010 period, in which sustained investment showed that it WAS possible to rebuild and revive an NHS that had been debilitated by 16 years of under-funding.

None of the advocates of 'alternative models' and more private sector involvement is willing to address the fact that the health insurance industry does not want to recruit older people (who are more likely to make a claim, and more likely to have more than one pre-existing condition) and charges hefty higher age-related premiums to deter them. The growth of "self-pay" private treatment for those without insurance cover has been much slower than the growth of the waiting lists – as the hefty costs and limited range of such treatments act as a barrier to most.

Private hospitals (average size 40 beds) are not geared up in any way to handle emergencies or complex cases, and have never shown any interest in doing so. In other words, even for the wealthiest people needing emergency treatment there is no private sector option that avoids the long

queues of ambulances and delays in accessing NHS A&E departments.

What is more worrying is that Liz Truss herself has embraced many of the right wing policies and "solutions". She is one of an 8-strong Parliamentary Board of the 1828 Committee, whose 'Neoliberal Manifesto', published jointly with the Adam Smith Institute in 2019, condemns the NHS record as "deplorable" and calls for the UK to "emulate the social health insurance systems as exist in countries such as Switzerland, Belgium, the Netherlands, Germany and Israel, among others." The Manifesto is silent on the fact that (with the exception of the deeply flawed Israeli system) all of its preferred models spend much more per head on health than the UK.



Source: Daily Mail

Open Democracy has also pointed to Truss's long-standing links to other right wing think tanks including the notoriously anti-NHS Institute for Economic Affairs, which, with the Adam Smith Institute appears to be the source of many of her ideas on the economy and the cost of living crisis.

So as Truss takes over, appointing yet another new health and social care secretary, the crisis could rapidly degenerate from the worst-ever to even worse.

That's why the broadest-possible fight has to be waged now, focused on the core issues of the funding deficit and the staffing shortages, and demanding a substantial emergency cash injection to cover an above inflation pay rise for staff, as well as capital investment to tackle the growing backlog of maintenance and rebuilding of crumbling hospitals and renewal of clapped out equipment.

The SOSNHS petition launched earlier this year for an emergency down-payment of an extra £20bn to rescue the NHS has attracted well over 300,000 signatures so far. This is now the bare minimum extra funding needed to stave of major and damaging cuts and the haemorrhage of staff to better-paid, less stressful jobs.

John lister

Latest policy ideas on social care: up to the challenge?

The social care system in England is in a state of crisis. The sector is struggling to recruit and retain staff, and as a result standards are falling, and many people are not getting the care services they need. There is also now the added issue of inflationary pressures and rocketing gas and electricity bills.

Liz Truss, the new Prime Minister, stated in one husting that she would divert the £13bn of funding earmarked for the NHS to deal with the Covid backlog to social care instead.

This idea was branded as "robbing Peter to pay Paul" by Richard Murray, the chief executive of the King's Fund, and "not a sustainable solution to the health and care crisis."

Social care has been in trouble for many years, but plans for reform have been kicked down the road by successive Conservative governments. Despite what Boris Johnson said in his leaving speech, he did not reform social care. In fact, it is now in an even worse state than before Johnson's term as PM as the long-term impact of years of austerity and the Covid-19 pandemic is being compounded by spiralling inflation and intense pressures on the labour market.

Whilst Truss's acknowledgement of the crisis in the social care sector is welcome, how her plans for the sector will make a difference are not clear yet.

There are reports that the new Health and Care Secretary, Thérèse Coffey, is examining proposals to re-introduce the Discharge to Assess programme used during 2020/21 to free up beds for Covid-19 patients. Under the scheme, care homes were paid to look after patients who were medically fit to leave hospital but could not be discharged because of a lack of social care.

The Department of Health and Social Care (DHSC) believes the scheme could free up thousands of hospital beds currently occupied by "delayed discharge" patients and so reduce the time

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taken for handovers by ambulance crews to A&E staff.

Funding for the original scheme was ended in March 2022, despite opposition from NHS Providers, the NHS Confederation and many others in the NHS. The cost of the new scheme would be in the hundreds of millions of pounds and would have to be approved by the Treasury.

However, the issue is broader than delayed discharge. More people than ever need social care, in particular due to mental health issues, domestic abuse and safeguarding concerns, and an increase in cases of breakdown of unpaid carer arrangements.

A recent analysis of care needs among the over 50s by Age UK found that 2.6 million people aged fifty and above, that's 12% of this age range in England, are living with some form of unmet need for care in England.

Companies lack staff to fulfil contracts

The major issue for care services is lack of staff. The latest data on vacancies in England shows that in 2021/22, there were 165,000 social care vacancies, that's almost 1 in 10 posts vacant, an increase of 52% from 107,000 vacancies in the past year.

Companies do not have the staff to take on contracts: ADASS, the Association of Directors of Adult Social Services, reports that 7 in 10 directors of adult social services say that care providers in their area have closed, ceased trading or handed back contracts to local councils, many due to staffing shortfalls.

The lack of staff has a number of consequences: quality of care is falling; staff become overworked and stressed leading to problems retaining staff; and delayed discharges from hospital increase as no home care plan can be set up. Delayed discharge from hospital has a knock-on effect on A&E and elective surgery, increasing waiting times and leading to cancelled surgery. HSJ recently reported that there are cases of people waiting months for discharge from hospital.

Caroline Abrahams, charity director at Age UK, told HSJ that the shortage of home care is "crippling patient flow in many hospitals" and has created an "utterly miserable situation". She said this has been caused by "low pay and poor conditions" in the domiciliary care sector.

A recent analysis of care home reports by the Guardian found that staff shortages were identified as a key problem in three-quarters of all the care homes in England where the CQC had downgraded their rating from "good" before Covid-19 to "inadequate" in summer 2022. Problems identified due to a shortage of staff included being left in a room all day, assaults by other residents due to lack of supervision, and residents left in urine-soaked clothes.

It is undoubtedly pay that is the crucial issue in recruitment and retention of staff. A Care England survey in August 2022 reported that in their exit interviews, when asked why they were leaving,

two-thirds of staff cited pay, just under half cited stress, and a third negative work environment and shortages in staffing.

The minimum rate for staff over the age of 23 in June 2022 was just £9.50 an hour, the statutory minimum set by the national living wage. And it has been estimated that around 50% of care workers earn within 30 pence of the national living wage level.

It is difficult for the companies to attract staff when local supermarkets and hospitality often pay better. In June 2022, The King's Fund reported that nine out of 10 supermarkets paid more than £9.50 an hour, with Tesco, Asda and Lidl paying £10.10 per hour. Care workers are also attracted away from permanent employment to work via agencies.

A Care England survey in August 2022 found that agency rates were significantly greater for carers (£19.57 vs £9.90) compared to employee hourly rates.

Better pay and conditions needed...

Care companies have had to pay bonuses, pay increases, retention payments and other financial incentives to retain staff, but although improved benefits and better training for staff is an objective for everyone in the sector, the companies say this current approach is not sustainable, in particular in light of additional inflationary pressures on food and utilities.

It is clear that for the sector to stand any chance of competing successfully for permanent staff in the current economic climate, it will have to improve pay and conditions permanently rather than on an ad hoc basis.

Unlike the NHS, the care sector consists of hundreds of companies, mainly privately-owned, but a significant number of not-for-profit companies and charities, of varying sizes each with its own individual financial situation. How then do you inject £13bn into the sector and get the desired result of more staff with better pay and conditions, leading to increased care services?

The Homecare Association has already written to Liz Truss, outlining what will be needed to ensure adequate availability of homecare services this winter and beyond; money to cover higher fuel costs incurred by home care workers, immediate financial support to manage the pressures of Covid-19 and influenza over the coming winter, and an increase in baseline funding for home care by at least £1.7bn a year to support recruitment and retention of care workers by enabling payment of wages equivalent to NHS Band 3 Healthcare Assistants.

Local authorities who commission vast quantities of care from these companies are in a position to incentivise care providers to pay higher rates, and probably would have done this over the years if chronic underfunding of local councils by over a decade of conservative governments hadn't taken place. As a result local authorities have been very limited in what they can pay these companies, making it harder for providers to increase wages in response to rising vacancies.

So in theory money targeted to local authorities would enable them to pay companies more, which could in turn lead to increased pay and better conditions for staff, increasing recruitment and improving staff retention.

Any proposed Discharge to Assess plan, however, would target the care home sector with money paid to homes to take discharged patients. Whilst there are many individual care homes and smaller chains of care homes that are struggling financially, this sector also contains several large companies, owned by private equity, which appear to be awash with money and which made large profits during the pandemic and the use of Discharge to Assess.

In July 2022, an investigation by the Centre for the Understanding of Sustainable Prosperity at Surrey University and Trinava Consulting with the trade union Unison, found that the UK's biggest care home chains saw their profit margins jump by 18% on average during the pandemic, while the highest paid director's salary surged to £2.3m. Meanwhile these companies continue to advertise jobs paying just £9.50 per hour.

A recent article in the New Yorker highlighted what happens in the USA when private equity takes over a nursing home; staff as the biggest cost are cut to a minimum, standards fall and as a result residents suffer more malnutrition, dehydration and bed sores, and they therefore make more visits to the emergency room (A&E) as conditions that would be prevented by good care go unchecked.

...but extra support may end up as profits

How the private equity owned companies in the US behave, gives an indication of how private equity owned companies in the UK care sector may respond if the local authority was able to pay more per patient or they get paid for Discharge to Assess – rather than increasing staff pay and improving conditions, they may well see it as more profit.

Unison has highlighted the growing role of private equity in the UK sector, finding that more than one in nine (12%) care beds in the UK were now in the hands of investment firms. The Held to Ransom report from Unison in June 2022 has already revealed cost-cutting at several unnamed firms, including allegations of food and cleaning products being replaced with cheaper substitutes and residents' meals being reduced from three to two a day.

Christina McAnea, the Unison general secretary, said: "The sector is on its knees, staff are leaving in their droves and those who rely on care are getting a raw deal. Yet many care home owners continue to see their financial fortunes soar amid this crisis. Root-and-branch reform is needed now with profiteering removed from social care."

NHS faces 'double whammy' as energy crisis bites

Health service leaders are pressing for extra government support, as the NHS faces up to the two-pronged impact of a looming energy crisis: rising demand from patients hit by the 'heat or eat' effects of fuel poverty, and rocketing costs from suppliers.

The likely impact of the government's current stance on raising the energy price cap for consumers prompted Sam Allen, chief executive of the North East and North Cumbria Integrated Care Board, to write to regulator Ofgem last week.

In her letter Allen expresses concern that energy supplies being cut would be "life-threatening" for many clinically vulnerable people, and put added pressure on a health sector that – in the words of NHS Confederation chief executive Matthew Taylor – is already "likely to experience the most difficult winter on record".

"[We] are starting to see examples where clinically vulnerable people have been disconnected from their home energy supply, which has then led to a hospital admission," Allen says. "This is impacting on people who live independently at home, with the support from our community health services team, and are reliant on using electric devices for survival.

"Put simply, the impact of having their energy supply terminated will be life-threatening for some people, as well as placing additional demands on already stretched health and social care services."

And last week saw similar initiatives to Allen's launched across the health sector, all calling on the government to take urgent action.

University College London's Institute of Health Equity published a report warning that 15m people – that's 55 per cent of households – are expected to experience fuel poverty by the beginning of next year, leading to a "significant humanitarian crisis" because of the increased risk of respiratory and cardiovascular illnesses caused by living in cold homes. The institute called for extra funding for local government to address the crisis.

That report followed on from a letter to chancellor Nadhim Zahawi from the NHS Confederation in mid-August, warning that the country could soon face a "humanitarian crisis" of poor health, excess deaths and increasing social inequality unless the government took immediate action, and noting that the health service in England already spends £1.3bn each year treating preventable conditions caused by cold, damp homes.

'Vicious cycle of healthcare need'

Assessing the likely impact on the NHS, the confederation's chief exec Matthew Taylor said in the letter, "NHS leaders have made this unprecedented intervention as they know that fuel poverty will inevitably lead to significant extra demand on what are already very fragile services. Health leaders are clear that unless urgent action is taken by the government, this will cause a public health emergency."

To back up its argument, the confederation explained how fuel poverty risks creating a 'vicious cycle of healthcare need': a patient presents at their GP with a chest infection from a mouldy bedroom, the GP treats the infection but the patient goes back to sleeping in the same bedroom, and so the infection recurs. The NHS then treats the symptoms again but, without treating the source of the problem, the symptoms continue to recur.

Given its earlier positioning, the government perhaps shouldn't be too surprised by the strength of the health sector's reaction to the energy crisis and the knock-on effects of fuel poverty. Last year the government launched the Sustainable Warmth: Protecting Vulnerable Households in England report, which acknowledged that warmer homes can reduce the frequency and severity of health problems. And Public Health England's regular Cold Weather Plans over the past decade offer ample evidence of the financial costs to the NHS of increased levels of illness due to cold weather – and also the relatively modest cost of repairing every household which currently has a 'hazard' rating for excess cold.

Will a price cap cover the NHS and care sector?

But regardless of the new Truss administration's approach to raising (or freezing) the energy price cap for individual consumers, both the NHS and the social care sector face rapidly rising (and, as corporate customers, unlikely to be capped) energy costs that could see the level of service each sector is able to offer the vulnerable being severely constrained this winter.

Research by the BMJ published last week showed some NHS trusts will now need an extra £2m each month, because their energy bills will be up to three times higher than last winter. A spokesperson for the NHS Confederation told the publication that these costs would "wipe out large parts of the NHS budget" and that – unless the government offers help – trusts will have no choice but to cut back on services.

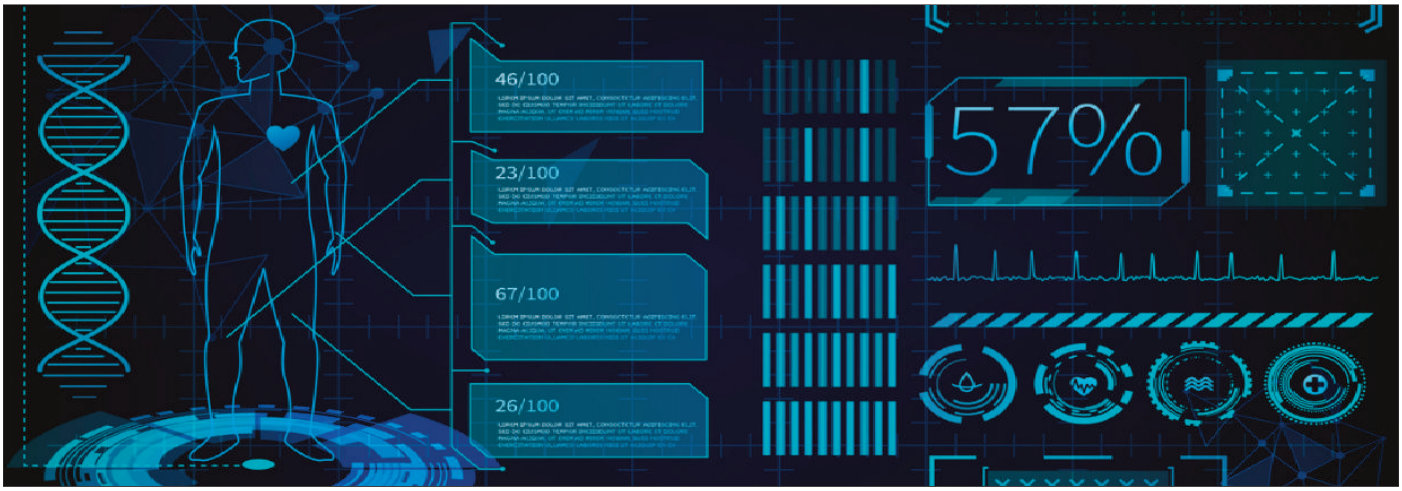
The BMJ found that Leeds Teaching Hospitals NHS Trust is preparing for increased gas and electricity costs of more than 100 per cent, while Nottingham University Hospitals NHS Trust has budgeted for an even larger rise – 214 per cent.

Figures obtained separately by ITV show four out of Wales' seven health boards are expecting rises of more than 200 per cent, and an FoI request by the Metro website has revealed that Manchester University NHS Foundation Trust is expecting a £4m hike in its energy bill over the next financial year.

And while NHS England has budgeted for a major increase in energy costs, its assessment back in May of the likely overspend – £485m – now looks hopelessly optimistic given the bleak forecast for the coming months, especially with no hope of prices being capped.

Even worse, those awaiting the government's new social care strategy, designed to ease the strain on the NHS, will draw little comfort from news last week that many care homes could be forced to close because of sky-high energy bills – said to be up in some cases by 600 per cent – unless the state intervenes.

Martin Shelley



More questions than answers on virtual wards

With 'virtual wards' being the latest big idea for NHS England to square the circle of trying to expand capacity with reduced revenue and no capital, all 42 Integrated Care Systems are required to establish them 'at pace'. So we might expect to find a wealth of explicit guidance for local NHS management seeking to set them up.

This should include a clear definition of what virtual wards are for, what they can and cannot be expected to achieve, minimum investment required in terms of staff (with guidelines for the necessary skill mix of staff to ensure the virtual ward works efficiently) and equipment required for the target provision of 40-50 virtual beds per 100,000 population, with costings so that required resources can be calculated.

We might also expect this information to be available for the press and wider public, who may well have concerns as to the viability of virtual wards, to convince them the schemes are well thought out, based on a clear model, and safe for patients and staff.

According to NHS England's web page, "Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital."

If this was being proposed with a guarantee of the necessary funding and staffing, with regular checks on outcomes, few would disagree that some patients would benefit from less intensive levels of care, assuming that home circumstances are suitable.

However a search through the same website for more information reveals that there is no discussion at all about assessing the home circumstances of the patients, and none of the concrete guidance we might expect: or if any such guidance does exist, it is behind a password barrier limiting the information to NHS staff.

Insufficient staff

Published NHS England guidance does say that "The virtual ward workforce commonly consists of:

"consultant geriatricians (hospital or community based); advanced clinical practitioners; pharmacists; nurses; AHPs [Allied Health Professionals such as therapists and radiographers]; GPs with specialist interest; health and care support staff; social care workers; plus operational support and third sector organisations.

But many of these staff are in desperately short supply, and no numbers are given to indicate how many of each per cohort of patients might be required to ensure safe cover (allowing for sickness and holidays) for "a minimum of 12 hours a day (8am–8pm), seven days a week, with locally arranged provision for out-of hours cover, enabling flexibility of service provision as determined by local need."

In other words the staffing requirement – and up-front cost – is substantial, and could in many areas only be delivered by reducing resources and staff cover elsewhere.

Some information is promised by a new range of private companies seeking to profit from this latest way of delivering health care, such as Current Health, Homelink Healthcare (whose Head of Business Development has previously held senior roles with IBM and United Health), and Spirit Health.

But since these are all selling a product, they are inevitably focused on accentuating the positive, ignoring the real problems, and making extravagant claims of cash savings per patient.

Idealistic vision

NHS England's web page features a film apparently showing a

virtual ward in action at Norfolk and Norwich University Hospitals NHS Foundation Trust (which turns out to be working with Homelink Healthcare).

This film reveals that the NNUH virtual ward has supported 857 patients "since Feb 2021" but does not define the period covered. This suggests as few as 50 patients per month are covered, which would explain the idyllic and leisurely way in which services appear to be delivered.

The too-perfect picture conjured up is reminiscent of the Jim Carrey film The Truman Show: so there always seems to be the right member of staff on hand with time to take on the necessary tasks to make each aspect of the virtual ward – down to promptly delivering prescription drugs to patients at home – but there is no mention of how many clinical and non-clinical staff are in the team.

The film shows a relatively young, articulate patient being given a beautifully packaged box of pre-programmed equipment including a tablet computer, oximeter, blood pressure monitor, and more which apparently "does not need internet," and no questions are asked about phone or broadband signal in the patient's home.

How will it be delivered?

Nobody discusses the cost of the boxes of kit, how many are given out, whether they are later collected back in, or where a trust seeking to set up a virtual ward can obtain a stock of them.

Is there a central supply, bought in bulk, or does each trust or each private company touting for business have to conduct its own procurement? Does each tablet need to be programmed to link to local systems, or has a generic system of apps been sorted?

But as well as the technical questions there is the big practical question: even if the patient is savvy enough to get the kit to work and produce its stream of information back to the virtual ward team, how thoroughly will it be monitored, and how many staff are needed to ensure this happens?

If the patient does feel unwell and push the 'red button' for immediate assistance, how likely is it, with the current chronic problems of ambulance and emergency services, that they will get the promised instant answer? Who is clinically responsible if a patient fails properly to use the kit and becomes ill with no health care worker within miles?

Is each virtual ward supposed to have its own team on hand 24/7 to deliver emergency response? What happens if two or three real patients in the virtual ward feel unwell at the same time? This can be hard enough to cope with on a real ward, but much more complex when patients are many miles apart.

The film shows phone calls being answered by unhurried qualified, uniformed hospital nurses, and additional nursing staff working in the community. How realistic is it to assume that all 42 ICSs can establish little islands of safe staffing – and beds for any virtual patients needing hospital care – while the rest of the NHS faces 110,000 unfilled posts, huge delays and a worsening shortage of beds?

Limited support, what next?

Moving on from the film, the web page explains "Support may also involve face-to-face care from multi-disciplinary teams based in the community, which is sometimes called Hospital at Home." Reading on we find this is limited: the inclusion criteria for Hospital at Home stipulate "Expected required treatment time is short-term intervention of 1 to 14 days."

There is no mention of this limit in the Norfolk & Norwich film, but another March 2022 guidance document on virtual wards also emphasises the same time limit, which appears therefore to relate to ALL virtual ward provision:

"Virtual wards provide acute clinical care at home for a short duration (up to 14 days) as an alternative to care in hospital. Patients admitted to a virtual ward have their care reviewed daily by a consultant practitioner (including a nurse or allied health professional (AHP) consultant) or suitably trained GP, via a digital platform that allows for the remote monitoring of a patient's condition and escalation to a multidisciplinary team."

So what happens after 14 days are up and patients still need support? Do they have to join the queue for an ambulance and a hospital bed?

Looking through the other documents on the NHSE website the questions keep coming: for example the 'Guide to setting up technology-enabled virtual wards' gives absolutely NO specifics or concrete guidance, no idea what kit should be provided as minimum, where it could come from, or how much it would cost. Worse still it has a lethargic lack of urgency:

"Teams should consider the technology partnerships and platforms already in place across their ICS in alignment with their digital strategy to support future scalability. Once the clinical and business needs are determined, a local requirement specification for the use of technology in a virtual ward can be developed."

Financial questions

Another NHSE guidance document does discuss funding, but in the most general terms, and emphasises that the extra cash this year and next is only temporary, so local providers will need to cover the full cost from 2024:

"£200 million of funding is available from the Service Development Fund (SDF) in 2022/23. … A further contribution of £250 million, on a match-funded basis, will be available in 2023/24. This temporary national funding will provide significant financial support to systems for the establishment of virtual wards but is not in-

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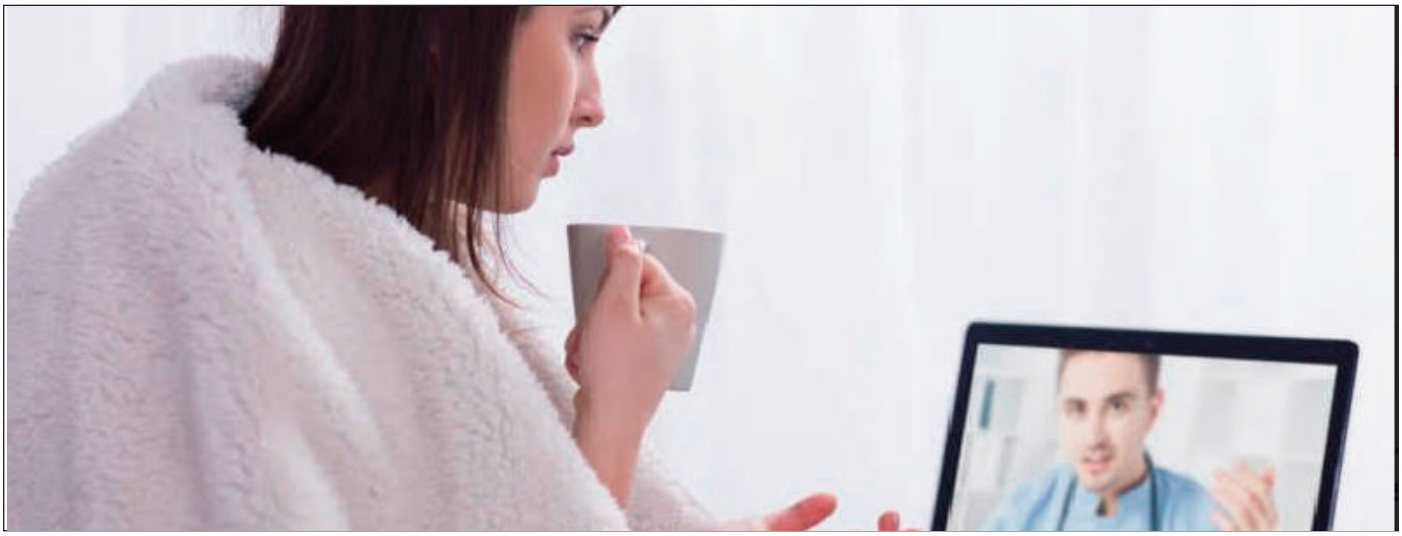
Uncertain future for Babylon Health in the UK



Recent moves by Babylon Health raise more questions on how long the company will remain a partner to the NHS, as it leaves contracts in the UK and looks to save money.

In the past month the company has announced the end of partnerships with two large hospital trusts in the Midlands – University Hospitals Birmingham (UHB) Foundation Trust and The Royal Wolverhampton Trust (RWT) – as the company says they are "no longer economically viable."

And the company's chief financial officer, Charlie Steel, has said the company cannot 'continue to fund the NHS forever' as it reported on losing money on its GP services for the NHS.

The two high-profile contracts are expected to end later in 2022.

The UHB partnership, which began in May 2019, covered the launch of the symptom checker service Ask A&E, whose use the trust hoped would reduce the pressure on its A&E and hospital services. However, it was not universally welcomed by GPs in the area.

A frightening prospect?

Pointing to funding problems in primary care and a lack of support for GPs, Birmingham local medical committee executive secretary, Bob Morley, said the chief executive of UHB Dr Rosser's vision of vertically integrated care, in combination with Babylon, was "a truly frightening prospect that is going to be nothing but massively damaging for healthcare in Birmingham".

The Ask A&E app will now be decommissioned. A spokesperson for University Hospitals Birmingham confirmed that the trust "served notice on the contract with Babylon Health in July and this collaboration will end in October".

The 10-year partnership with RWT, signed in 2020 is now ending eight years early. The deal was to launch "digital-first integrated care" across the region. The partnership which would have allowed patients to access NHS primary, secondary and community healthcare services through a single app, also used the Ask A&E app. In April 2020, the Royal Wolverhampton Trust and Babylon made available Babylon's newly developed Covid-19 app. Babylon and RWT then expanded its partnership in August 2021 with the launch of Babylon 360 to about.55,000 people across Wolverhampton.

Babylon has said that: "As a priority, we will work to ensure the safe and smooth transition of patients from the Babylon platform onto alternative providers."

The company still runs its GP business, GP at Hand, in the UK, which launched in London in 2016 and in Birmingham in 2019. Since November 2017 over 113,000 people across London and Birmingham have registered with Babylon GP at Hand. However, its popularity has become an issue, according to CEO Dr Ali Parsa.

At an investor event back in May, Parsa said that the company needs to be "very cautious" about expanding its business in the UK as it loses money on every patient it sees in its GP at Hand business. The company is paid for one or two visits per year to a GP for the age cohort registered with its service, but Parsa noted that "in reality, people use us six to seven times a year and we

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Now for the bad news as cancer care hits 'worst ever' performance

Barely had the BBC headlines trumpeting the achievement of virtually eliminating 2-year waits for NHS treatment in England faded from TV and radio news bulletins before the appalling revelations on worsening cancer treatment times were flagged up.

Figures leaked to the HSJ and shared with BBC's Newsnight team showed almost a third of a million people (327,000) are on cancer waiting lists in England, almost 40,000 of them waiting for treatment to begin more than 62 days after a GP referral.

Worse still numbers waiting over 104 days have more than doubled in a year, to more than 10,000: in 2018, NHSE said there should be "zero tolerance [of] non-clinically justifiable 104-day delays".

Despite a ridiculous statement from NHS England, apparently dictated by Department of Health and Social Care spin doctors, diverting attention from the desperate under-resourcing of cancer care by claiming to be investing "billions in extra diagnostic and treatment capacity," the BBC report quotes Prof Pat Price from Imperial College London warning that:

"The waits for cancer treatment are the worst they've ever been – and they're getting worse. We have to get on and address this crisis. This is an absolute disaster."

Indeed the most recent official cancer waiting time figures show how far performance has fallen back in the past year, even as the peak of the pandemic has passed.

In the year since April-June 2021 numbers of cancer patients have increased by less than 5% to 676,000: but the number missing the standard for a 2-week maximum wait for a first consultant appointment after an urgent GP referral has rocketed by almost 48%, from 91,000 to 135,000.

Compared to pre-pandemic (April-June 2019) numbers of patients have increased by 15%, but longer than target waits have more than doubled (up 160% from 58,000 to 135,000).

It's 8 years since services for patients with suspected breast cancer met the target of ensuring 93% receive appointments within 2 weeks.

Performance failing even pre-pandemic

Nor is it any consolation for NHS England to aim in its elective services recovery plan to restore performance to pre-pandemic levels: one month waits for treatment have not been on target since the summer of 2018, and the proportion within target has continued falling despite reduced numbers of patients.

It's even worse with the 62-day (two month) target, which has not been met since early 2014: in the past year while numbers of patients have increased by 2% to 43,000, numbers waiting longer than 62 days have increased by 71% to 16,000,

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tended to cover the ongoing cost of the service.

"No ringfenced recurrent funding will be made available from 2024/25. Systems will therefore need to ensure virtual wards are built into long term strategies and expenditure plans."

£200m is equivalent to less than £5m per ICS, and less than £1.5m per acute hospital trust. So it's most unlikely even to cover the capital cost of procuring the kit and establishing an operational base for the 'virtual ward' – let alone the staffing costs. The guidance does not say what the money is supposed to cover, or what additional costs may be incurred.

To make matters worse this has to be implemented at a time when the newly-established ICSs are required to generate total "savings" of £5 billion, inflation is ripping into the high double digits, the pay award is under-funded, a crazed potential Prime Minister is threatening to slash £10bn from NHS budgets to give to privatised social care, and 110,000 clinical posts are vacant.

And while acute trusts are struggling to create 'virtual' beds, the problem of efficiently using the existing actual beds continues unabated. Six in 10 hospital patients who are medically fit for discharge are stuck in hospital for lack of social care, with fewer than 9,000 patients out of the average of 21,741 patients each day assessed as well enough to be sent home actually being discharged in July.

And with a further 6,400 Covid patients in hospital beds in mid-August, even hitting the target of 7,000 virtual beds would still leave the NHS with over 19,000 beds (almost 20% of the total of acute beds) unavailable for emergency or elective care.

As a practical solution to today's actual problems, it seems virtual wards are virtually useless.

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actually lose money on every member that comes in".

Dr Parsa also said the company is 'overwhelmed with demand' for GP services in the UK.

GP at Hand allows patients to access video consultations or see a GP in person at one of Babylon's practices in London, where more than 90% of its patients are based. The company had seven practices in London, but despite the emphasis on digital-first and video consultations, there has been a big rise in demand for face-to-face consultations, forcing the company to open two new clinics in London. GP at Hand also has a clinic in Birmingham.

As a result of pressure on finances, in July, Babylon announced a series of "cost reduction actions" to generate $100m (£82.1m) in savings. Bloomberg reported that jobs will be cut, with about 100 Babylon employees in the UK and US, including from the clinical safety and compliance teams.

Recent years have seen Babylon focus its business in the USA, rather than the UK. In October 2021, the company went public on the New York Stock Exchange via a merger with Alkuri, a special purpose acquisition company (SPAC) with an implied equity value for Babylon of about $4.2 billion

In June 2022, the FT reported that Babylon and many other small cash-intensive companies who took this approach to listing on the market, have suffered a massive fall in value as investors sell-off the shares as the companies fail to fulfil the rosy-projections given when they went public. Babylon's market capitalization has fallen more than 90%, giving the company a market value of about $334 million. Its share price has fallen from around $11 in October to around $1.

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and performance is falling back, with just 62% treated within the standard time.

With these figures already in the public domain it's no surprise that NHS England should not be keen to publish the figures now leaked by the HSJ which show 10,189 of the 327,395 people on the national cancer waiting list – around 3 per cent – had waited 104 days or more, around double the figure from a year ago, with a further 28,406 having waited between 62 and 103 days as of the end of July.

The HSJ notes that one in four of the 42 Integrated Care Systems that now run England's NHS are reporting performance worse than the national average, although some ICSs in the south east are doing better than average. The Lowdown has warned that most, if not all ICSs face tough targets for so-called 'efficiency savings' this year, and the Nuffield Trust's Sally Gainsbury has estimated these will add up to more than £5 billion, meaning there is minimal scope for investment to address these problems.

But despite the misplaced optimism of the NHS England statement it's clear cancer care – as only one of a whole range of services in need of improvement – has not been given sufficient priority in an under-funded and over-stretched NHS that has been denied the resources necessary to hit the targets it has been set.

But things are set to get worse rather than better, with chronic staff shortages, hospitals lacking beds for emergency as well as elective admissions. NHS England has also threatened to cut back on its investment in diagnostic technology – a key bottleneck area for cancer care – as a result of government refusal to fund the excess costs of the controversial 2022 NHS pay award.

John Lister

To help secure the future of our NHS through campaigning journalism, please support us

Dear Reader

Thank you for your support, we really appreciate it at such a difficult time. Before covid-19 the NHS was already under huge pressure, and after it's all over there will be a backlog of patients, queues of people affected by the crisis, and a hugely tired workforce.

From that moment we will need a much more credible plan to fund, support and protect our brilliant NHS. Our goal is to help make this happen and we need your help. We are researchers, journalists and campaigners and we launched The Lowdown to investigate policy decisions, challenge politicians and alert the public to what's happening to their NHS.

It is clear from the failures of recent years that we can't always rely on our leaders to take the right action or to be honest with us, so it is crucial to get to the truth and to get the public involved. If you can, please help us to investigate, publicise and campaign around the crucial issues that will decide the future of our NHS, by making a donation today. Our supporters have already helped us to research and expose:

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

First we must escape the covid-19 crisis and help our incredible NHS staff. We are helping by reporting the facts around the lack of protective equipment for hospital staff but also for thousands of carers. We are publishing evidence about more community testing and the shortcomings in our strategy to beat the virus. Even though they have a tough job, there have been crucial failings: on testing, PPE and strategy, and we must hold our politicians to account and challenge them to do better. We rely on your support to carry out our investigations and get to the evidence.

If you can, please make a regular donation, just a few pounds a month will help us keep working on behalf of the public and NHS staff - thank you. We all feel such huge gratitude and respect for the commitment of NHS staff and it's so impressive to see such strong public support. Let's hope that we can give the NHS the thanks it deserves and crucially, secure its future.

With thanks and best wishes from the team at The Lowdown

EVERY DONATION COUNTS!

We know many readers are willing to make a contribution, but have not yet done so. With many of the committees and meetings that might have voted us a donation now suspended because of the virus, we are now asking those who can to give as much as you can afford.

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

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

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

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