The lowdown

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

Weak Coffey plan won't stimulate crumbling NHS

Therese Coffey's much vaunted new plan for the NHS, ridiculously titled Our Plan For Patients is neither new nor a plan. It lacks both of the elements that are needed to make its limited promises a reality: extra funding and a plan to secure sufficient workforce.

The main selling point to grab headlines was declaring an "expectation" that a patient who needs an appointment with a GP within two weeks should be able to get one.

But this is a feeble and belated echo of the guarantee made in 2000 by New Labour's NHS Plan that all patients would be able to see a GP within 48 hours by 2004, and indicates how far the NHS has declined since George Osborne slammed the brakes on spending back in 2010.

In fact, Coffey is proposing that 3 million people seeking to see a GP (about 1 percent of the total demand for ap-

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pointments) should instead be offered appointments with pharmacists, physiotherapists and other health professionals, who may or may not be seen as able to answer the problems that are raised.

The vague and evasive wording circles round the fact that Coffey cannot compel GPs to cap waiting times at two weeks: that would require renegotiation of the GP contract the Department of Health and Social Care agrees every year with the British Medical Association. It would mean talking to people: this government does not do that.

Indeed Coffey's announcement was drawn up in a few days without bothering to consult GPs or the wider NHS, and crudely cobbles together odds and ends from previous NHS England policy guidance.

Hollow claims

It claims to "sit alongside the NHS Long Term Plan, the forthcoming workforce plan, and our plans to reform adult social care." But the Long Term Plan has already been effectively derailed by the lack of funding, capital to invest in new projects, and staff: the 'workforce plan' has been repeatedly promised, but stalled since at least 2014 by the refusal of the Treasury to commit to the resources needed to recruit and train additional staff.

And the hollow claim by the Johnson government to have 'fixed' social care is almost comically exposed by the chronic problems hospitals face in discharging patients for lack of social care support.

Labour's plans from 2000 that made it possible to bring down waiting times in A&E and a maximum 18 week wait for elective care as well as improved access to GPs were backed by a decade of significant investment in the NHS and expansion of its staff. By contrast today's threadbare promises made by Coffey follow 12 brutal years of real terms cuts in spending and years of broken promises to increase numbers of GPs. There are now 1850 fewer GPs in post than there were in 2015.

To make matters worse the right wing newspapers and news media that eagerly backed the Truss takeover of the Tory Party have also been conducting relentless campaigns of vilification against GPs, disregarding the astonishing effort GPs have made to increase numbers of appointments in spite of their growing caseload and the additional tasks dumped upon them by NHS bosses.

Indeed 85% of appointments already take place within two weeks, and 44% on the same day as the request. Contrary to the assertions of the right wing press, two thirds of these appointments are face to face: 30% are telephone consultations, often more convenient and efficient for both doctors and patients. To insist that all have to be face to face would inevitably reduce the number of appointments available.

Where's the new funding?

Coffey's plan claims to "focus relentlessly on ABCD – ambulances, backlogs, care, doctors and dentists." But this leaves out so many pressing issues (e.g. A for anaesthetists and other staff shortages; B for beds and actual front line capacity; C for collapsing hospitals and the £9bn-plus of backlog maintenance; D for dementia and the dreadful gaps in mental health services which never feature at the top of any priority list). It also lacks any commitment of new funding or resources.

Even the £500 million now allocated for a short-term a 'Adult Social Care Discharge Fund' is not new money. And the announcement that this Fund is to be cobbled together from reallocating cash from the DHSC budget is followed in the Plan by an ominous commitment to "further action from next year to rebalance funding across health and care, to establish a strong and sustainable social care sector with

greater accountability for use of taxpayers' money."

Given PM Liz Truss's few statements on the NHS and social care, this seems to threaten that any increased funding for social care will be snatched from an already inadequate NHS budget.

Token gestures

With no more cash on the table the whole statement is reduced to the trivial and token gestures. The response to ambulance delays is to recruit more call handlers to answer the phones quicker, and once more to repeat the tired old nonsense of trying to redirect patients away from A&E:

– "dedicated 24/7 helplines for patients experiencing a mental health crisis"
– supporting the NHS to better redirect patients to … urgent care centres, walk-in centres or minor injuries units
– expanding the use of remote monitoring of patients at home …
– expanding "falls prevention and falls response services, to avoid unnecessary ambulance call-outs and emergency admissions"

Ms Coffey is apparently oblivious to the fact that these alternatives have been tried and failed in the past. They need more staff and resources and much better community and primary care provision to make them possible … and are simply irrelevant for the most serious Type 1 and Type 2 patients who need ambulance services and are most likely to need a hospital bed, but face the longest delays.

Coffey's plan to expand hospital capacity is to "open up the equivalent of 7,000 beds" – an idea plagiarised from the vague and unconvincing plans from NHS England for "virtual wards" which we have previously discussed at length in The Lowdown.

Moving on to B for backlogs, Coffey's plan is similarly recycled verbiage from the NHS England Delivery plan for tackling the COVID-19 backlog of elective care – which we know is heavily dependent on utilising private sector beds and facilities, and impeded by the dire staffing shortage.

Stale pledges

Coffey also repeats stale old pledges to recruit 50,000 more nurses by 2024 ignoring the official figures showing 132,000 vacant clinical posts in England and other statistics showing the increasing numbers of staff leaving the NHS through burn-out, or for less stressful, better-paying jobs elsewhere.

And her only substantial reference to mental health focuses not on the proven and widening gaps in care, but waffles vaguely about "access to NHS talking therapies, children and young people's mental health services and enhanced community support for adults living with severe mental illnesses and expanded support in schools." With no new resources on offer and mental health staff shortages generally the highest in most areas, none of the bland words will lead to any real change.

On C for Care, Coffey has nothing of substance to say apart from promising a £15m effort to recruit staff from overseas which we know already will struggle to attract anyone given the appallingly low pay and poor conditions of work in social care, and the huge obstacles to overseas recruitment erected by previous Home Secretary Priti Patel's vicious immigration laws.

And on D for Doctors and Dentists the main focus is NOT how to recruit, train and retain the necessary qualified staff, but on piling more pressure on GPs alongside vague promises of new incentives to dentists.

A volunteer service?

But with insufficient staff, no new money, soaring inflation and energy costs and local NHS Integrated Care Boards facing demands to cut spending this year to balance the books, Coffey tacitly admits the system can only work if she can persuade more people to fill in the gaps by working for nothing as 'volunteers':

"To succeed, we need a national endeavour. That could involve clinicians who have retired to return to work or opening up opportunities for the million people who volunteered to help during the pandemic, like becoming community first responders or Good Neighbour Scheme leaders."

While thousands were indeed willing to volunteer to assist the NHS in the fight to tackle the pandemic, it's far from clear that the same reservoir of good will and dedication would apply to apparently indefinite unpaid voluntary work to bail out an NHS that has been deliberately and systematically under-funded by a government seeking to line private pockets rather than protect and develop our most popular public service.

If ministers took the future of the NHS seriously they would be applying a 'laser like focus' on recruiting, training and paying a new army of recruits to deliver services safely and effectively rather than trying to cobble together a Dad's Army of retired staff and well-meaning but unqualified volunteers to plug the gaps they have created in 12 disastrous years..

John Lister

Labour Party vows to train thousands more NHS staff

In front of delighted delgates, the Labour Party has profiled its response to the perilous workforce crisis in the NHS at its conference in Liverpool.

In speeches by both the Leader, Keir Starmer and the Shadow Chancellor, Rachel Reeves they announced new targets and investment in NHS staff training.

To cheers from delegates Reeves said: "The next Labour government will double the number of district nurses qualifying every year,"

"We will train more than 5,000 new health visitors. We will create an additional 10,000 nursing and midwife placements every year."

Labour promised to produce a long-term workforce plan for the NHS for the next five, 10 and 15 years and said it would "implement the biggest expansion of medical school places in British history, doubling the number of medical students so our NHS has doctors it needs".

Reeves revealed that Labour would pay for the policy by reintroducing the 45% tax rate, creating a clear water in policy terms with the Truss government - on both tax, and their-commitment to fund workforce expansion.

Missed targets

The Conservatives made manifesto promises to introduce 6000 more GPs and 50,000 more nurses.

There are now 1,608 fewer fully qualified full-time equivalent GPs today than there were in 2015.

Despite ministerial claims to be on track with nursing recruitment, the target will be missed by 10,000 according to the latest predictions.

District nursing numbers have fallen by 46% since 2009, and are down over the last 5 years too, while caseloads are climbing.

For community nursing as whole, mental health nursing and learning disability nursing, the numbers are all already lower than they were in June 2010, according to the Health Foundation.

Efforts to reach recruitment targets have partly been undermined by the fact that many more NHS staff are leaving their jobs, to retire or to escape work pressures.

For Labour to be successful it must contend with all sides of the workforce problem - training, recruitment and retention.

Released this week, the board minutes from Kingston hospital show how NHS trusts are wrestling with all three factors. The trust has a 17% turnover rate of nursing staff, 4% above their target. It blames the slowing of the inflow of international nurses since 2020 and the high number of qualified nurses leaving in 2021, which has increased by 39%. 45% of those leaving the trust moved to another NHS Trust, 22% retired and 17% cited work life balance as their reason for leaving.

Overall, the UK ranks below the average of high-income OECD countries in terms of both the number of practising nurses and the annual number of new nurse graduates, relative to its population. It has just under eight practising nurses per 1,000 population, while the OECD average is nine. Germany has more than 13 nurses per 1,000, while Australia has 12 and Belgium and the Netherlands each have 11.

Steep challenge

As previously discussed in the Lowdown, Analysts at the REAL centre calculated that by 2030/31, up to an extra 488,000 health care staff would be needed to meet demand pressures and recover from the pandemic - a 40% increase in the workforce and double the growth seen in the last decade.

They also found that 6oo,000 extra social care staff would be needed – 55% more, and 4 times greater than the increases of the last decade.

GPs slam new health secretary's 'Plan for Patients'

The new health secretary Therese Coffey's new "Plan for Patients" under which patients should not have to wait more than two weeks to see their GP, is already receiving considerable criticism from GPs.

Prof Martin Marshall, chair of The Royal College of GPs (RCGP) has accused Coffey of expecting already hard-pressed GP surgeries to meet new targets, without a plan to deliver them:

"Lumbering a struggling service with more expectations, without a plan as to how to deliver them, will only serve to add to the intense workload and workforce pressures GPs and our teams are facing, whilst also having minimal impact on the care patients receive".

Prof Marshall also noted that: "around 85% of appointments in general practice are already happening within two weeks of being booked, with 44% being delivered on the day they are booked – both higher figures than in 2019 – and those taking longer than two weeks after booking may be routine or regular appointments for which the timing is therefore appropriate".

What is needed, Prof Marshall, added is: "the implementation of a new recruitment and retention strategy that goes beyond the target of 6,000 GPs pledged by the Government in its election manifesto, funding for general practice returned to 11% of the total health spend, investment in our IT systems and premises, and steps to cut bureaucracy so that we can spend more time delivering the care our patients need and deserve."

Responding to the Health Secretary's announcement, Dr Farah Jameel, chair of the BMA's GP committee for England, said: "She could solve this better with meaningful dialogue and constructive engagement with GPs rather than yet another new set of ill-advised undeliverable targets….If the new Health Secretary had met with us before this announcement we could have suggested a workable strategy to address the unfolding crisis before us for this winter and beyond – instead we have in reality minor tweaks that will make no tangible difference to patients struggling to access care."

Coffey also plans to:

– use pharmacists, physiotherapists and other health professionals, many working in surgeries, to free up 3m GP appointments per year

– fund better cloud-based telephone systems for practices to help callers get through more quickly

– increase the number of people with minor ailments seeing high street pharmacists

– make GP surgeries publish appointments data

Dr Jameel noted that surgeries already have good telephone systems, just not enough staff to answer the calls.

And the RCGP are concerned that the publication of appointments data could lead to a "league table" of GP surgeries, something that does nothing to improve access to or standards of care.

"Introducing arbitrary performance rankings compares apples with pears and will only serve to work against and demoralise those working in practices that 'rank' lower."

In reality the fundamental issue is lack of staff, in particular GPs. The number of GPs in England has fallen every year since 2015. There were 29,364 full-time-equivalent GPs in post in September 2015, but by September 2020 the number of family doctors had dropped to 27,939, a fall of 1,425. NHS workforce data for June 2022 show the number has fallen still further to 26,859.

The plan put forward by Coffey will do nothing to solve the problem of falling GP numbers. A recent survey by the Kings Fund, which found that 63% of trainee GPs in England plan to work no more than six four-hour "sessions" a week one year after qualifying, highlights how difficult it will be to fill vacancies

Those replying to the survey said they do not want to work any more shifts than six because the job is so intense and the extra work generated by seeing patients, such as referral letters, means a four-hour shift actually takes six or seven hours.

Prof Marshall noted that: "GPs need to be freed up to deliver the care that we know patients so desperately need – that means we need a genuine strategy to address the workforce crisis. There simply aren't enough GPs and staff to deliver the care our patients need and deserve."

Wes Streeting, the shadow health secretary, reminded Coffey that the last Labour government had given patients a right to see a GP within 48 hours – "until the Conservatives scrapped it"..

Patients set to suffer as primary care buckles

With GPs seemingly under fire from all sides – offered up as a diversionary punch-bag by some in the media while the government continues to underfund and mismanage the wider NHS – financial and recruitment issues in the primary care sector are putting patients' health at risk.

Practices across the UK are expected to see profits plummet by up to a third over the next 12 months, according to one recent survey. The medical accountants association AISMA told Pulse magazine that, largely because of rocketing energy costs, rising inflation was eating into many practices' budgets, and many of them would be left with no alternative but to cut staff or, even worse, shut down and hand back their contracts with the NHS.

That scenario goes some way to explaining the current GP recruitment crisis which has led to a shortage of 4,200 full-time-equivalent doctors across England – a figure which could hit almost 11,000 within the next decade, according to the Health Foundation thinktank.

Financial considerations must surely have played a part too in the picture emerging from Pulse magazine's investigation last month, which found that over the past decade almost 480 practices – often in deprived areas – have permanently closed without merging with nearby practices or being replaced, in the process leaving close to 1.5m patients without a local GP.

Stress levels among already hard-pressed GPs, widely reported, is an inevitable knock-on effect of this scenario, and the situation hasn't been helped by health secretary Therese Coffey's controversial – but largely unenforceable – 'plan for patients', which aims to force doctors to see patients within two weeks of an appointment.

And the impact of those stress levels is only adding to the primary care sector's recruitment problems, with the Royal College of GPs chair Professor Martin Marshall recently putting it: "A burnt-out GP is not able to practise safely."

That awareness is echoed in this month's study from the King's Fund thinktank, which found that – because of safety concerns – just over 60 per cent of trainee GPs in England were planning to work part-time only, ie no more than six four-hour stints a week, after qualifying, and that barely 30 per cent were considering working full-time. The study also found that trainees were increasingly reluctant to become partners in GP practices because of the huge responsibilities involved.

Another impact is the growing presence in the private sector of former practice GPs, seeking to escape the pressures and prioritise their mental health – in the process exacerbating the staff shortages within the public sector.

In a recent interview with inews.co.uk, one such practitioner outlined the reasoning behind her decision to 'go private'.

"A typical clinic for me [used to be] starting at 8.40am until about 12noon, full of ten-minute appointments. Then you repeated that again in the afternoon. It's very intense. You're seeing about 30-26 [sic] patients a day, and in some places it will be more. It's quite a heavy workload. [Now] we have 20-minute appointments at our private clinic, which is probably standard for most private GPs – some will offer 30 minutes."

The current cost-of-living crisis might make the expansion of the type of private surgery this particular GP works for – and the take-up among less affluent patients of the services it will offer – an unlikely prospect over the short-term, but the creeping privatisation of the work of local NHS-contracted surgeries continues, with often negative consequences for existing NHS patients.

Just consider the experience this month of one local practice in Lancashire, where the launch by the county's ICB of a seasonal tourist triage phone line – costing £170,000, and apparently to be run on a for-profit basis by another contractor – was matched by the withdrawal of £73,000 in funding for the local practice, leading to the handing back of its NHS contract.

So now that government ministers are demanding that GPs provide shorter waiting times, they must surely ask themselves, "What are we doing to support them?"

Martin Shelley

Controversial plans to shift NHS funding to social care on hold

The potential catastrophe which was feared could be included in the September 23 mini-budget and in Therese Coffey's first policy statement as Health and Social Care Secretary has not materialised … yet.

The NHS Confederation and NHS Providers had both warned of the consequences if the Truss government implemented her proposal to "raid" NHS finances and take up to £10bn a year from the most recent extra cash allocated – to hand it to social care.

Others also feared that such a rapid, near 50% increase in social care spending would simply allow the chaotic array of private providers of domiciliary care and care homes to jack up their prices and profits.

There is no national coordinating body in charge of social care: no body able to ensure extra spending leads to any increase in provision of care or even improved pay to help fill the 160,000 vacant posts in social care (almost all of which offer pay scales that compare poorly with less stressful jobs in supermarkets and elsewhere).

Nor is there any means to ensure that the largest care home chains, controlling one in nine social care beds, but owned by profit-hungry private equity investors, don't just siphon off any extra funds to benefit shareholders.

However the fears, while not misplaced, have been slightly premature. Coffey's sketchy, short term policy paper "Our Plan for Patients" proposes only to launch a "£500 million Adult Social Care Discharge Fund" (not new money, but a reallocation of funds already in the DHSC budget).

This temporary fund is supposed to take the place of the 'Discharge to Assess' funding, brought in to speed discharge of patients from hospital during the pandemic, that was scrapped from April this year.

But as winter approaches, the continued pressure on acute beds from a new rise in numbers of Covid patients (back up to more than 5,100 on September 21) and an average of over 12,000 patients each day occupying hospital beds for lack of social care support, mean over 17% of beds are unavailable for 'normal' work.

That's why NHS front-line capacity is nowhere near sufficient to treat emergencies and elective cases – leading to a continuing rise in waiting lists to 6.8m.

More changes on the way

Nevertheless, ministers are still threatening far-reaching and damaging changes, vaguely described by Coffey as: "further action from next year to rebalance funding across health and care."

Coffey argues this is needed to establish "a strong and sustainable social care sector with greater accountability for use of taxpayers' money." But it's certain that the damage that would be done to the NHS by any substantial outright cut in funding would massively outweigh any possible benefit from improved social care.

Cutting the full £10bn of extra funding per year would amount to a 7 percent reduction – far and away the biggest-ever actual cut in NHS funding, dwarfing the cutbacks imposed under Margaret Thatcher in the 1980s.

And while Chancellor Kwasi Kwarteng's tax-cutting "mini-budget" promised that the extra funds promised to health and social care from the now scrapped "health and care levy" would still be paid, there has been no announcement of additional funding for the NHS.

The Lowdown and SOSNHS have explained that, after 12 years of real terms cuts, billions more are needed to enable the NHS to weather the massive rise in inflation. SOSNHS has argued for a down-payment of £20bn, to be followed by further increases.

These are needed to cover the substantial increase in pay needed to stop the exodus of demoralised, under-paid staff from the NHS, fill 132,000 vacant posts, repair crumbling hospitals and expand capacity to meet demand and tackle backlogs and waiting

lists in acute services, mental health community services and primary care.

Any claim that such funding is not affordable has been shot down by Kwarteng's massive spree of tax-cutting that benefits only the top 1% of tax payers and big business, and the handouts to the energy companies. These add up to £161bn of reduced tax income and increased government borrowing over the next 4 years.

Unrealistic approach

Kwarteng's measures also mean energy companies will preserve windfall profits of up to £170bn, while leaving millions of households and small businesses with unpayable inflated energy bills, as the general cost of living increases at rapid pace.

The market reaction to Kwarteng's profligate and reckless squandering of cash on the wealthiest few suggests that few are convinced leaving millions in poverty, and unable even to pay for necessities, is a realistic way to grow the economy.

Instead it runs the risk of worsening physical and mental ill health among the poorest and piling more pressure on the NHS.

Already the money markets are demanding big cuts in public spending to reduce the level of increased borrowing.

To make matters worse, the 'mini-budget' has already further collapsed the value of the pound, giving another boost to already rocketing inflation.

The ultimate danger of all this is that when it all goes wrong any panic package to rescue the economy (as happened back in 1976 in the aftermath of similar tax cuts by Tory Chancellor Anthony Barber in 1972) is almost certain to again include a fresh crackdown on public spending and prolonged, even deeper, austerity.

Meanwhile Rishi Sunak's three-year plan to claw back much of the "extra" spending on the NHS during the peak of the Covid pandemic remains in place. It is at the core of huge financial pressures on the 42 Integrated Care Boards that have taken charge of England's NHS since the Health and Care Act was implemented in July. This puts every ICB under pressure to generate 'savings' totalling £5.5bn – and plans will need to be in place this autumn.

The worst scenario has not yet taken place – but the present reality is bad enough.

John Lister

More than 70 groups decry move to 'weaken' public health measures

Liz Truss's plans for the UK's anti-obesity strategy, which could see the axing of many measures to help reduce the country's intake of fat, salt and sugar, have been labelled as 'disastrous' by experts and "profound concern" has been expressed by health and medical organisations in an open letter to Truss.

The open letter, coordinated by The Obesity Alliance, is signed by over 70 organisations including the BMA, Diabetes UK, British Liver Trust, British Dental Association, Royal College of Nursing, Cancer Research UK, British Heart Foundation, and the Royal Society for Public Health. The sheer breadth of health areas covered by the signatories' organisations reflects just what a major and broad impact obesity has on health.

The letter reminds Truss that by implementing the "forward thinking policies," of the obesity strategy that are "grounded in strong evidence," the health of the nation will improve and "thus increase economic growth and reduce state spending."

The letter strongly urges Truss "to reconsider any plans to weaken the public health measures."

Measures in the strategy that might be dropped include the 2018 'sugar tax'. This introduced a tax on high sugar products, particularly targeted at fizzy drinks. Other measures, that could be axed, are only just being introduced, such as calorie labelling on menus, and a restriction on the location in retail for foods high in fat, salt and sugar scheduled for implementation next month.

Two other major policies, restrictions on multibuy deals and restrictions on advertising on TV and online, have already been delayed, until October 2023 and January 2024, respectively.

Obesity is a major issue in this country, with almost two-thirds of the adult population in Britain overweight or obese. With the prevalence of adult and childhood obesity much higher in deprived communities, any measures to tackle the issue will benefit less well-off communities the most.

The cost to an already over-stretched and underfunded NHS is massive. In 2019/20 there were more than 1 million hospital admissions linked to obesity in England, an increase of 17% on the previous year. Obesity-related conditions include diabetes, heart disease, cancer, and musculoskeletal conditions. The cost of obesity to the NHS is forecast to rise to £9.7 billion per year by 2050.

The government's anti-obesity strategy, although it did not go as far as many campaigners wanted, was a step in the right direction. Efforts to reduce salt, sugar and fat through voluntary measures previously had largely failed to have any impact.

The first measure – the 'Sugar Tax' – has proved highly successful. A study published in early 2021 in the BMJ concluded that the sugar tax had been very effective at making manufacturers reformulate products – lowering sugar content to avoid higher prices for their products.

A 'disastrous' move

All parts of the anti-obesity strategy are based on strong evidence, notes Professor Graham MacGregor: Chairman of the charity Action on Sugar and Salt, and scrapping it would be "disastrous to both public health and also to the many food businesses which have spent years and vast amounts of money preparing for this change in policy."

"Now, more than ever, the UK population needs equitable access to healthy, affordable food and this can only be achieved with policies designed to rebalance our food system."

Katherine Jenner, the director of the Obesity Health Alliance, a grouping of over 40 health charities and medical organisations, told the Guardian:

"There are few policies that are good for business, good for health and good for government. The soft drinks industry levy [sugar tax] is one of them."

According to a Guardian report, however, Truss will have difficulties repealing the sugar tax "as Whitehall sources say there is "a question mark" over how the prime minister can overcome a number of legal and parliamentary procedural obstacles to abandoning the soft drinks industry levy."

In fact, all the measures scheduled for introduction are already in law, so any reversal of the strategy would mean parliamentary time being given over to repealing laws put in place within the last two years and with the current high inflation and cost of living crisis, this hardly seems a good use of precious parliamentary time.

Popular support for current strategy

There is strong support from the public for the strategy as well. A recent survey carried out by YouGov for Cancer Research UK, found 60% of people support the restrictions on junk food advertising, as well as a ban on paid-for online junk food advertising being implemented in January 2023 as originally planned. Just one in five disagreed with the ban.

Truss has dressed-up scrapping the changes as being about helping people in the cost of living crisis, but it's hard to see how it will help.

Chief executive of Cancer Research UK, Michelle Mitchell, said: "Claims by industry and the Government that these delays will help address the cost of living crisis are grossly misleading."

Not only has the sugar tax raised around £1 billion since it was introduced to fund important activities like school breakfasts for vulnerable children, but the evidence is that the planned changes in advertising, marketing and location of junk food will actually save people money as they will buy less junk food, less often.

And in the long-term reducing obesity will reduce the cost to the NHS.

The only clear winners of any move by Truss to scrap the changes in the obesity strategy are the food and drink manufacturers, who will be able to continue using advertising and marketing strategies that encourage bulk buying of junk food.

Even before Truss became PM, there was evidence that the government's commitment to tackling the obesity epidemic was waning rapidly. In April 2022 the government removed £100 million in funding for NHS weight management services, despite research showing that these services, a broad range of health advice, information and behaviour change support services, can be an effective intervention to support lasting health improvement.

The cut to services was condemned at the time by the Obesity Alliance, which accused the government of "'short-termism', where services that deliver long-term benefits are sacrificed for short-term savings."

At the time there were also rumours that despite widespread public support of the measures to tackle junk food marketing and advertising and it already being law, the strategy was under review.

Warnings and lessons from abroad

As the international money markets respond with a universal thumbs down to the extreme dose of neoliberalism unveiled in the Truss government's first "mini-budget", with the pound plunging in value against all currencies from the Albanian lek to the Zambian kwacha, it seems a good time for The Lowdown to take stock of the wider international policy context.

Unhealthy inequalities

The new British government's determination to discard even the pretence of "levelling up" and embrace a full-throttle widening of the chasm between rich (feted with tax cuts) and poor is certain to increase the tide of ill-health and increased demand for NHS acute and mental health services.

If anyone doubts this, they should look to the situation in the USA, where President Biden has arbitrarily declared the Covid pandemic over while hundreds are still dying with it each day. The US has experienced its biggest decline in life expectancy since the First World War – with the heaviest death toll predictably centred in the poorest states and the most deprived communities.

A new report has shown that "states with the lowest life expectancy at birth were mostly Southern states (Alabama, Arkansas, Kentucky, Louisiana, Mississippi, South Carolina, Tennessee, and West Virginia) but also included D.C., Indiana, Missouri, New Mexico, Ohio, and Oklahoma."

A recent article on the Salon website notes the for-profit healthcare system, "which limits both access to care as well as public health surveillance," and the lack of universal health coverage have contributed to the death toll. The US has just 4.25 percent of the world's population, but its million-plus COVID deaths are more than 14 percent of the world's total.

A recent pandemic study, 'A Poor People's Pandemic,' shows how the burden has fallen on to poor and low-income communities, with poor and low-income counties experiencing death rates that were twice as high as richer counties, and up to 5 times higher at different phases of the pandemic.

But of course there are winners from this brutal system. The Biden administration's decision to end the free distribution of COVID tests and vaccines, a move predicted by the Wall Street Journal on August 19, is expected to lead to a "windfall for drugmakers," generating "sales for companies — and costs for consumers — for years to come."

The great social care rip-off

Meanwhile another comparison with the situation in Britain is the emerging pattern of intervention by private equity companies seeking smash and grab raids in pursuit of short-term profits from social care companies.

Held to Ransom, a recent report sponsored and published by UNISON, has highlighted this problem in the UK: but a series of very useful pamphlets commissioned by Public Services International, the global federation of public sector unions, helps to understand that this phenomenon is increasingly evident in other developed countries.

All three reports were published in May this year, and respond to the Covid crisis as well as the wider issues of Long Term Care (LTC). The overview, Long Term Care: effects of pri-

vate provision sums up:

"As many traditional industries continue to decline, global investors have increasingly pivoted toward the care sector, with nursing home real estate in particular functioning as a lucrative sink for financial capital. The transformation of LTC into an investment product is widely seen as attractive for investors for offering low-risk and high returns, thanks in large part to government funding, rising unmet demand, and a lack of regulation on the quality of care provision."

It goes on to note: "The dominant market-based model for LTC has seen incredibly uneven growth and geographic inequality, both on an international scale, as well as within countries. The developers of nursing home real estate are not guided by concerns of unmet care needs, but rather the promises of highest profitability.

"LTC is highly dependent on government financing as a source of revenue. Profit-making in the sector is understated, and clashes with public perceptions of thin profit margins due to chronic underfunding, especially in light of austerity policies.

"LTC is often seen as under-resourced, yet there is no shortage of private investment flooding into the sector. Nursing homes were a booming industry prior to the pandemic, with extremely high profitability … in some countries, rates of return for investors in private LTC have been reported to be several times higher than the average for other industries."

And it argues that in both Europe and the USA: "The COVID-19 pandemic has turbo-charged an investment boom, seeing a new wave of market consolidation in private LTC and the transfer of non-profit nursing homes into private ownership…"

We know of course that in the UK profit margins of the biggest care home chains rocketed during the pandemic, inflating the already sky-high level of chief executive pay. But while it works well for shareholders the model has been repeatedly shown to deliver poor value and poor quality care for patients.

"Research has accumulated that shows that ownership of LTC has a significant impact on the quality of care and life expectancies of nursing home residents. A key difference that emerges from many studies comparing for-profit, non-profit and public facilities is the adequacy of staffing. Key indicators of quality – hospitalisations and mortality – have been documented to be significantly worse in for-profit facilities in the US, UK and Canada."

For PSI the conclusion of their research is the need to fixing the care crisis, through "a shift away from notions of a 'care economy' towards that of the social organisation of care."

Britain started the rot

Care Givers and Care Takers: How finance extracts wealth from the care sector and harms us all uses the British example, which began under Margaret Thatcher in the 1980s to explain the elements of what has become an international problem:

"… long before Covid hit, another deadly trend has been wreaking havoc in care. …. The first, better- known part, is the privatisation of a sector once largely provided by the state. This has been problematic and widely criticised, for the profit motive does not sit comfortably with the care imperative, but this privatisation juggernaut has pushed steadily forwards for decades. "In 1979, for instance, nearly two out of three residential and nursing home beds in the UK were provided by the State; by 2017 this had fallen to one in twenty.

"At the same time, austerity in many countries has meant that government spending on the sector has stagnated or fallen."

However the pamphlet is focused on the less well-known and understood changes that have been taking place:

"Academics call it "financialisation". Some have spoken of it as 'capitalism on steroids.' What this means is that financial actors, such as private equity firms, hedge funds or banks, have become increasingly active in this sector as financial investors. They often deploy tools, techniques and tricks – each quite legal, many highly acquisitive, often involving large-scale borrowing – to syphon wealth out of this sector for themselves, instead of investing for better care."

This invasion of the care sector means that pumping in more funding cannot guarantee any improvement or expansion of services: "… if more government money is pumped into private care, extractive financial tricks may be deployed to hoover some or even all of it up, before it can reach patients and care staff.

"For example, a new US study found that some $5.3 billion in pandemic relief went to 113 private equity-owned companies, which had a collective $908 billion in cash reserves or "dry powder" available in 2020. Many used their cash reserves to pursue aggressive new buyouts, and in many cases shed workers."

Solutions not necessarily easy

"One simple and effective way to end financialisation in the social care sector is to make care public. Another approach is to regulate financialisation out of the care sector, and impose much greater levels of accountability and transparency. Even then, though, it is likely that the pressure for financialisation to creep back in will be omnipresent. Ultimately, financialisation is a curse on all sectors and in the long term should be eliminated from the entire economy."

With special relevance to the situation in Britain under the Truss government, the report goes on to shoot down the notion that it's necessary to give incentives to billionaires and finance capital to ensure the economy and services expand:

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"We're told that policies such as higher taxes on billionaires or tighter regulation of bank risk-taking will threaten jobs, investment and prosperity, and damage the supposed 'engine' of the economy …This report shows that the exact opposite is true: allowing an oversized financial sector to grow too big does not only redistribute wealth upwards and damage the economy: it shrinks the pie overall.

"This 'finance curse' – a concept supported by widespread research from some of the world's top academic institutions, shows how "too much finance makes us poorer." The core reason for this apparent paradox is that once a financial sector grows beyond its useful roles, it turns increasingly to wealth extraction, as opposed to supporting wealth creation. This report lays out some of the extractive techniques at work in the care sector."

Handbook

The third, much shorter (16 page) PSI pamphlet, Ten Tricks: a short handbook of financial engineering, describes ten of the most important Private Equity (PE) tricks in simple and accessible terms. It is intended to provide a more in depth analysis of financialised techniques.

Anyone wanting to get to grips with the contradictions of social care, or understand the truly parasitic and destructive role of private equity capital should get hold of these important studies – and share their conclusions widely.

Kicking long-stay patients into care homes

Meanwhile in Ontario the right wing provincial government led by Doug Ford is giving an object lesson in how government can bulldoze through "reforms" to Long Term Care that benefit only the private care home owners, and strip patients and their families of any rights.

The Ontario Health Coalition has strongly opposed the latest moves, and the following is an extract from their Press Release on September 15.

The Ford government released its regulations under the euphemistically titled 'More Beds, Better Care Act' on September 15. The legislation gives new powers to push elderly patients and people with chronic care needs out of hospitals, overriding their right to consent, backed up by the threat that patients who refuse to move will face charges of $400 per day, or $2,800 per week.

Hospitals will be "required" to charge the exorbitant fees not only to patients waiting for long-term care, but also those waiting for home and community care.

The new regulations stipulate that in southern Ontario patients can be sent up to 70 km away from the hospital. In the much less populous North the limit is theoretically 150 km – but if there are no beds available within 150 km, patients can be sent even further. Since there are no beds available (there are 38,000 people on the LTC wait list) this will happen.

The new law gives new powers to:

– Assess a patient without their consent

– Share that patient's personal information with an array of health provider companies (for profit and non-profit) without their consent

– Fill in applications for the patient without their consent

– Admit a patient into a long-term care home without their consent, including a long-term care home that is far away, has a bad record for care, is not of the patient's choice, does not meet their language needs, etc.

These changes may result in patients being pushed out of hospital into retirement homes, back home to wait for home care that may not materialize, or to other facilities or places.

Ontario has the fewest hospital beds of any province in Canada – and about the same level of provision as England.

Patients in these beds who have nowhere appropriate to go are not "taking up" resources, they need care. Hospitals have always provided a range of care including chronic care (complex continuing care), palliative care, rehabilitation beds and more. Those services are of equal importance to acute care and it is not in the public interest to allow them to be cut and routinely discounted.

There is a staffing crisis, commensurate to the hospital staffing crisis, in long-term care and in home care in Ontario,. Despite repeated demands – with concrete recommendations – to get the Ford government to take real action on the staffing crisis the government has taken little real action.

Only a minority of patients defined as needing 'Alternate Level of Care' (ALC) are waiting for long-term care. A significant number of them are waiting for hospital beds – complex continuing care (chronic care), rehab, mental health beds and others.

The Ford government cynically claims that the forced moves are temporary and patients will find their way to a LTC home of their preference is also cynical. Crisis admissions from hospitals always take precedence. The forced move is very likely the last move of the patient's life.

We may wonder how long it may be before the British equivalent of the Ford government, Liz Truss's right wing cabinet, draw similar conclusions on how to shift the average of 12,000-plus patients who on any given day are clinically fit for discharge but cannot leave hospital for lack of social care.

Perhaps in our case the desperate shortage of social care beds and home care services may even serve as a barrier to more barbaric solutions.

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