The lowdown

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

Action on hospital bed shortage: too little, too late?

Last winter In distressing scenes across the country patients waited in vain for ambulances, in hospital corridors and queued in hospital car parks. In total 23,003 excess patient deaths in England in 2022 were associated with long waits in the Emergency Department. A lack of available hospital beds was one of the key factors, so what are the plans to increase the number?

After a decade of watching hospital bed numbers decline by over 10% while hospital activity has been consistently rising, the government's announcement of a specific target to raise bed numbers by 5000 could be seen as a u turn. The announcement was first made back in January along with funding of £1 billion to pay for the additional capacity,"as part of the permanent bed base for next winter. (2023/24)", and has been included in NHS England's recent plan for winter 2023/4.

In response NHS leaders welcomed aspects of the wider winter plan, but were clear about how the plan would fail without extra support on funding and staffing and urgent action to resolve ongoing industrial disputes.

Matthew Taylor, chief executive of the NHS Confederation, said, "..the financial settlement provided for the NHS and required to effectively fund this plan, is not enough. We should be honest about this".

Progress with bed numbers so far?

Since April 2022 the number of NHS hospital beds has risen by 1284, largely due to a rise in general and acute beds – only a third of the way to the government's target.

Will 5,000 be enough?

Dr Adrian Boyle, president of the Royal College of Emergency Medicine (RCEM), believes the extra 5,000 pledged by the Prime Minister is less than half of the 11,000 additional staffed beds that are necessary to get a grip on the overcrowding crisis in the NHS.

Achieving the target would mean only an extra 20 beds in each of the 150 hospitals with large A&E departments, according to the RCEM.

Safe enough?

Estimates about the bed capacity that is needed are based on the safe levels of bed occupancy. The RECM, BMA, NHS providers and the National Audit Office are amongst the

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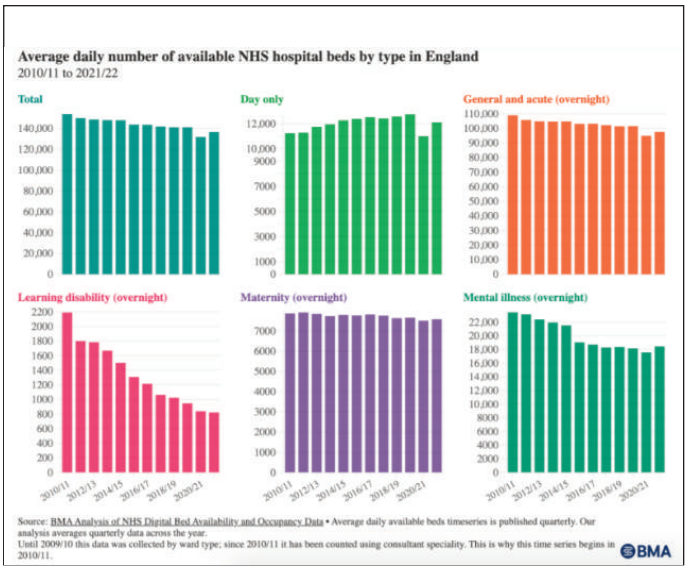
commentators that have concluded that 85% occupancy is an effective safe limit. Spare capacity is needed to avoid compromising care during busier periods and for effective infection control.

Bed occupancy rates in the NHS have been rising since



2010, when they averaged around 85% and are currently around 92% for general and acute beds. However, many trusts experience rates of around 95 during busy periods.

NICE acknowledges the research supporting the 85% limit, but suggests a "pragmatic compromise" of 90% occupancy on the basis that appropriate levels can vary according to factors like the type of hospital department and the proportion of complex cases.

NHS England accommodates an even greater level of risk though, aiming for 92% occupancy in its winter plan. The risk is the normalisation of the proven impact upon patients and staff from working close to the limit of capacity on a day to day basis.

What are the long-term trends?

The total number of hospital beds fell in most years in the decade before the pandemic.

The current level of hospital beds is 13,592 lower than the number of beds in the NHS in 2010/11.

There are also 6000 fewer general and acute beds, a lack of capacity that has heavily contributed towards A&E delays.

For much of the last decade the NHS has been doing more inpatient work with less available beds.

Hospital activity rose by 21% 2010/11-19/20 16.1 -2010/11 – 25 million (2019/20), despite a two year dip during the pandemic (measured by the number of finished consultant episodes). In fact the NHS is still struggling to reach pre pandemic levels of activity. A&E attendances have risen by 55%.

Impact on other services

Rising A&E workloads see accompanying pressure on GPs and ambulance services to also work too close to their safe limits. The consequences are damaging and without a quick fix.

UK GPs experience the highest stress and lowest job satisfaction compared to GPs in 9 other high-income countries.The workload on ambulance staff is having dangerous impacts upon patients and staff. 85 per cent of ambulance workers have witnessed delays which have seriously affected a patient's recovery. 82 per cent feel the current pressure on ambulance workers puts them at an unacceptable level of stress.

The situation in social care is no less pressured, as a survey of councils finds that they are not confident they can meet minimum social care support.

Much focus is on workflows and the communication between services which undoubtedly can produce improvement, but for too long long term planning in the NHS has not responded to fundamental shortages in staff and resources, and yet it remains by far the most influential factor to achieve sustainable services that can respond to our communities health needs.

Short-term over long-term?

The successive failure of governments to adequately plan around NHS workforce needs means that even a relatively modest increase of 5000 beds is proving hard to deliver.

Record numbers of staff are leaving the NHS, up 13% in the last year. Whilst 8% of all medical posts are vacant and 10% of nursing posts, and consequently the NHS is struggling to expand capacity in the short term.

Over the last decade NHS staff numbers have consistently not kept pace with the rising numbers of hospital patients. Action has been painfully slow, funding inadequate and the policy focus has been on managing demand and not increasing supply. The recently published NHS workforce plan was first promised in 2017, and despite pressure from NHS leaders was delayed several times, and for NHS leaders the funding for adequate staffing levels still remains absent.

As training staff in the NHS takes time, retention and overseas recruitment are the main short term options for raising staff numbers. Again funding, policy alignment and long term thinking is crucial. It seems that these plans to raise NHS bed capacity have arrived too late and are again not adequate to meet the depth of the hole the NHS is now in.

Task force packed with privateers backs outsourcing plan for NHS recovery

A barrage of publicity surrounded the publication last week of the long-awaited report of Rishi Sunak's 17-strong "taskforce" on elective recovery, which was set up last December.

There was no surprise that its focus was on ways of maximising the use of private hospitals and on getting private providers to run new Community Diagnostic Centres (CDC).

A quarter of the 17 places on the taskforce were taken up by representatives of the private sector: (Independent Healthcare Provider Network (IHPN) boss David Hare, Dr Paul Manning, chief medical officer of US-owned Circle Healthcare, owner of the UK's largest chain of private hospitals, Darsjak Shah from private eye health firm Newmedica, and Medefer CEO Dr Bahman Nedjat-Shokouhi).

In addition to minister Will Quince the taskforce also included two right wing government advisors, Robert Ede from neoliberal think tank Policy Exchange and Bill Morgan, founding partner from PR and lobbying firm Evoke Incisive Health whose clients have included the IHPN, the now-defunct Virgin Care – which sued the NHS over a lost contract, and private mental health provider Cygnet – owner of two hospitals exposed by a BBC Panorama investigation and by CQC inspectors.

With this substantial lobby group on board, many of us were braced for some dramatic proposals. Even more so when it was launched at a Downing Street summit which aimed "to 'turbo-charge' use of the private sector to help clear record waiting lists, as pressures on the NHS grew.

But in the event the taskforce has produced a fairly limited set of proposals, most of which are even less adventurous than the proposals to expand and effectively create a new NHS-funded private sector outlined by New Labour minis-

ters in Tony Blair's and Gordon Brown's governments from 2003 onwards.

Sadly Labour's shadow health secretary Wes Streeting showed again he has learned and forgotten nothing from those costly experiments, which paid private providers an average of 11% above the NHS rate for each patient treated. He picked up where New Labour had left off … and criticised the Sunak government's slowness in resorting to private hospitals!

Promoting the report, health minister Maria Caulfield shocked and confused the Daily Mirror and some campaigners by inaccurately claiming on Sky News that the government is spending "about £19 billion a year" on private providers (which, if true, would represent a near-doubling of almost £11bn (£10.85bn) spent on "independent sector providers" in 2021/22). She also claimed that although £19bn "sounds like a huge amount, it's actually only 8% of the NHS budget": but for £19bn to be just 8% of the budget, the budget would have to be a massive £237 billion – almost 50% higher than NHS England's actual budget of £167bn for 2023/24.

Caulfield seems to have been following in recent Tory ministerial tradition by just making up figures and relying on the (seemingly unlimited) ignorance of interviewers to allow them to go unchallenged.

In reality the striking thing about the taskforce report is that unlike New Labour's plans to sponsor the growth of new "independent sector treatment centres," backed by increased funding, the taskforce plan is backed by no extra funding at all: it is simply diverting more existing NHS funds into contracts with the private sector.

The main headlines on the report were grabbed by the announcement of 13 new "community diagnostic centres" (CDCs), eight of which are to be run by the private sector.

Five of these in the South West (on permanent sites in Redruth, Bristol, Torbay, Yeovil and Weston Super Mare) are to be run by one company, InHealth, which hit headlines back in 2019 when they landed a controversial 7-year contract to provider PET scan services in Oxfordshire against the opposition of local clinicians and politicians. It's not clear which firms will run the other three CDCs in Southend, Northampton and Birmingham.

The five new NHS-run CDCs will be in Hornchurch, Skegness, Lincoln, Nottingham, and Stoke-on-Trent. In total, the new CDCs will deliver over 742,000 additional tests, checks and scans a year.

Apparently NHS England has so far approved over 50 schemes with independent sector involvement, including fully independent sector-led CDCs, joint service delivery models and CDCs that have made use of independent sector-delivered mobile diagnostic facilities.

However no financial details of the initial investment or running costs, or other details of the size, scope and staffing requirements of CDCs are given, except we are told the five new NHS-run CDCs are to be funded from the £2.3bn pot announced back in the 2021 Spending Review.

And while the attention of the news media and campaigners focused on the newly-announced CDCs, few if any reporters have been asking how big or expensive these units will be. The report's 'case study' on CDCs states:

"Currently over 200 Independent Sector Providers (ISPs) provide over 10,000 diagnostic procedures per week to the NHS".

That means they are tiny. Each ISP averages just 50 tests/procedures per week: and the whole private sector contribution over a year is the equivalent to slightly more than the 479,000 diagnostic tests and procedures the NHS delivers every day.

The government has further muddied the water in assessing the scope and scale of existing, new and planned CDCs by publishing only a monthly cumulative total of procedures carried out since July 2021, and not giving the relevant number of CDCs in service month by month. However these figures do allow us to calculate that the 114 CDCs that have already come on stream delivered an average of around 240,000 procedures per month over the year to May 2023, and a total of 2.8 million in the year to April 2023.

From all the evidence so far it seems clear that unless the new and future CDCs are much bigger than the CDCs opened so far, adding 13 more CDCs, which are expected to provide 742,000 additional scans, tests and checks each year, is going to make only a minimal inroad into the delays and increasing numbers of patients waiting for diagnostic tests.

The government's declared ambition is to roll out 160 CDCs across the country by 2025 to increase capacity by 9 million tests, checks and scans a year, with the programme "backed by" the same £2.3 billion of diagnostics investment. So far the annual total of tests increased by 10.3% in the year from April 2022, to 18.8m per year. But to increase by 9 million would require a further 38% increase (7.2m) – a massive target – well beyond the scope of the remaining 43 that have not yet been announced.

A King's Fund Briefing warned last autumn that there may not be enough skilled staff to run both the new centres and pre-existing facilities: "Moreover, without a diagnostic workforce strategy, staff shortages and skills gaps may undermine the additional community capacity that the centres are aiming to create."

The problem is all the greater because the one thing the private sector, with its focus on profit, is consistently worse at than the NHS is recruiting and retaining staff. This was behind the collapse of community health service contracts and the ignominious failure and premature abandonment of the privatisation of management of Hinchingbrooke Hospital.

After 13 years of real terms cuts in funding, the NHS lacks capital for buildings or equipment. So the possibility of renting some facilities from the private sector might make some sense as a short-term expedient. But getting the private sector to staff and run the services – inevitably recruiting staff from the same shallow pool the NHS relies upon – makes no sense at all.

In July last year, the Royal College of Radiologists raised concerns about staffing levels, highlighting that their 2021 Workforce Census had identified a shortfall of 30% (1453) clinical radiologist consultants and 17% (163) clinical oncology consultants in England. The Society of Radiographers (the staff who take the X-rays and administer radiotherapy) which has been engaged in strike action over pay, is also concerned at staff shortages, and there is a chronic shortage of scientific staff.

Deputy chief executive at NHS Providers, Saffron Cordery, while accepting the increased reliance on the private sector, has also warned that an increase in diagnostic capacity has to be matched by increased capacity across the health and care system to deliver the treatments patients need once diagnosed. This is lacking.

She also urged the government to give the NHS "the capital funding it needs now and in the longer term to expand its own diagnostics capacity amid a backdrop of growing patient demand."

Given their prominence in the news, it may be surprising that the CDCs are not even the main event in the skimpy, repetitive 10-page taskforce report . Much of its focus is on ways of using so-called "patient choice" to persuade more patients to choose private hospitals or clinics for their elective treatment.

As the report's introduction (signed by Minister Will Quince, NHS England director Sir Jim Mackey … and IHPN boss David Hare) puts it, the hope is to: "speed up the treatment of patients by championing their right to choose where and when they are treated. Our expectation is that these measures will quickly play a key role in increasing the use of independent sector capacity …"

The taskforce proposes various measures to crank up the pressure on patients and their GPs to choose private providers, who we know are desperate to fill large numbers of empty beds as the cost of living crisis and high costs of private care limit the numbers able to afford to 'self-pay' – even as the waiting list soars to 7.5m. The private sector has said it has capacity to do an extra 30% of the work it was doing for the NHS before the pandemic.

It calls for improvements to the online electronic referral system, and for all patients needing elective care to be offered a shortlist of a minimum of 5 providers ("where clinically appropriate"). This is almost identical to controversial New Labour proposals almost 20 years ago.

NHS England is also apparently developing a new patient-initiated Digital Mutual Aid System (DMAS) that will enable patients to request to move provider:

"From the end of October 2023, all patients who have waited more than 40 weeks without having had their first outpatient appointment will be able to initiate a request to transfer to another provider."

There will be a "patient-facing comms campaign" starting from August 2023 to "ensure patients know about their right to choose and how to exercise it," and DHSC, with NHS England support, will "update the NHS Choice Framework to help patients understand the choices available to them in the NHS."

Nowhere is there any recognition of the limited size and scope of private hospitals, which mean that if too many NHS patients are persuaded to choose them they too will inevitably begin to build a waiting list and delay treatment.

The taskforce repeatedly reiterates the claim that the backlog was "caused by the pandemic," although all the evidence points to a chronic shortfall in NHS capacity as a result of 13 years of under-funding.

It looks to remove "obstacles to new providers offering healthcare services," and reinstate what was then called the "payment by results" (cost per case) system of funding that was introduced by New Labour in the mid 2000s to facilitate the diversion of funds from NHS to private providers.

The new proposal is for: "a return to paying according to the amount of elective activity delivered to allow integrated care boards (ICBs) to move elective activity across providers, including to independent sector providers."

New guidance has just been issued by NHS England "ensuring commissioners operate in compliance with their obligations in line with current legislation," while aiming "to revise patient choice legislation and establish the Provider Selection Regime (PSR) in 2023," – all to make it easier to refer patients to private providers and harder not to:

"the PSR will be a new regulatory regime to govern the procurement of healthcare services in England. This is intended to improve avenues for providers

who are suitably qualified to deliver clinical services."

Ominously, the taskforce also seeks to establish a new so-called 'independent panel,' which will "review compliance with patient choice and PSR requirements": effectively acting as enforcers to badger commissioners, GPs and trusts that fall short of the expected level of referrals to private providers.

The NHS workforce plan is effectively redefined as a plan to ensure "the NHS and independent sector has access to a sustainable workforce". And in what could be an important move towards the further exploitation of junior doctors, there is a proposal to extend the limited amount of "training" of junior doctors in private hospitals which have contracts for a substantial volume of NHS patients.

This is one reason NHS England are developing the 'NHS Digital Staff Passport', which will go live in December 2023 – a verified virtual record of a doctor's training and occupational health records – "reducing the administrative burden of moving between providers."

In addition the 'doctors in training' group, which for some reason comprises the IHPN, NHS England and the Royal Colleges "will continue to ensure barriers to junior doctor movement are minimised."

NB Editor/sub: Suggest pull out these highlighted pars as a box for emphasis

The NHS has also just started publishing regular data on independent sector use "showing the independent sector's contribution to tackling the backlog." Despite all the evidence that their aim is to divert the least complex elective patients from the NHS to private providers, the taskforce report claims:

"This [data] will also help to ensure that independent sector activity is additional rather than displaced NHS activity."

In fact the data so far underlines what a minor and insignificant role the private sector has played in delivering patient care. They show that in the year to April 4 2023, private hospitals treated just 105,000 NHS-funded elective in-patients and 650,000 day cases, and delivered 665,000 diagnostic tests and procedures.

By contrast England's NHS in the most recent statistics (2021-22) treated 7.9 million elective in-patients, 6.8 million day cases, 6.2 million in-patient emergencies and 17million diagnostic tests.

IHPN boss David Hare, in an article on the 75th Anniversary of the NHS tried to justify a greater role for the private sector. But he admitted (as the Lowdown has shown from ICB Board papers) many NHS managers, facing tight financial constraints, have been looking for ways to reduce rather than increase their reliance on the private sector:

"IHPN recently conducted a survey among our members, looking at engagement with the NHS planning process for 2023/24. 60% of respondents reported being asked by their local NHS to do the same or less activity as in 2022/23."

He goes on: "I understand the reasons. Of course it's understandable that NHS trusts – themselves under extraordinary financial pressures – want to retain work. However, we also need to ask – with 7.4m people on the waiting list – and with more than 300,000 people having waited more than a year – are we pulling out all the stops? Are we doing everything we possibly can?"

Mr Hare, of course, wants us to ignore the costs and consequences of NHS reliance on private hospitals:

the small scale and limited scope of private hospitals (average size 45 beds);

the fact they can handle only the least complex cases – limiting the numbers of NHS patients for whom their hospitals are "clinically appropriate", and leaving the NHS with reduced resources to deal with the most complex, costly and difficult cases;

the fact that private hospitals can only expand their work by recruiting staff from the same inadequate pool of qualified staff as the NHS;

and the fact that diverting all the least complex cases (and the funding for them) to the private sector dislocates the training of doctors, which is the responsibility of the NHS, and requires a varied case mix to equip tomorrow's specialists to deal with the full range of the NHS caseload.

In other words using apparently "empty" or "spare" capacity from the private sector not only lines the pockets of their shareholders, but comes at a heavy price to the NHS.

The most logical and efficient way to expand capacity in health care in England is to expand the NHS, not divert vital resources, staff and funding, into small-scale, profit-seeking private businesses.

While the government may be able to push through the proposed changes in legislation before the next election, and make use of the desperate shortages of capacity they have created by years of underfunding to effectively force more referrals to private hospitals, this blatant move to undermine the NHS and boost the private sector should be a major focus of the election campaign, along with the dire consequences of 13 years of austerity funding and neglect.

Any incoming government committed to the values of the NHS should commit to reversing such changes, and properly funding the NHS instead of diverting funds and staff to prop up a parasitic alternative..

John Lister

Study links private equity to poorer care

The takeover of healthcare services by private equity (PE) funds is associated with a worse quality of care and higher costs, according to the largest study ever undertaken on the effect of PE ownership published in the BMJ, and regulation could be needed.

The authors of the review, led by the University of Chicago, said "The current body of evidence is robust enough to confirm that PE ownership is a consequential and increasingly prominent element in healthcare, warranting surveillance, reporting and possibly increased regulation."

PE firms use money supplied by a combination of wealthy individuals and loans to buy companies, often ones that are struggling, with the aim to sell them at a large profit as quickly as possible (generally within 3-5 years). In order to make the profit quickly, the companies use a variety of approaches – breaking-up companies, merging small companies, selling off assets separately, making large numbers of redundancies, and generally cutting costs wherever possible.

In the past decade, these firms have invested in, acquired and consolidated healthcare facilities, with global healthcare buyouts exceeding £157bn since 2021 alone.

The systematic review in the BMJ considered 1,778 studies and evaluated 55 studies with the correct inclusion criteria across eight countries, although with a heavy bias on the US market (47 studies). The researchers looked at studies in a range of healthcare settings, with nursing homes the most commonly studied, followed by hospitals, dermatology, and ophthalmology. The impact of PE takeovers on costs, quality of care and health outcomes was assessed.

The researchers found that PE ownership was "most consistently associated with increases in costs to patients or payers" and was "associated with mixed to harmful impacts on quality." Furthermore, the review identified "no consistently beneficial impacts of PE ownership."Nine of 12 studies revealed higher costs to patients or the funders of healthcare at services owned by such firms, three found no differences, and none showed lower costs.

When quality of care was assessed, of 27 studies, 12 found harmful effects, three found beneficial, nine found mixed, where some measures declined and some improved, and three were neutral.

The researchers note that in some cases PE ownership was associated with reduced nurse staffing levels or a shift towards lower nursing skill mix.

The review was heavily biased to the US, but PE is a global phenomenon, and the researchers note that there is a need for rigorous research on such ownership in healthcare, in other non-US settings, such as Europe.

Earlier this year, in April, an article in the European Journal of Public Health also called for such research into PE.

The article noted that such investment in Europe's primary care sector seems to be increasing in many countries, but that there is no information on its impact on access to care, competition, data protection and health care costs.

In the UK, PE is invested in some notable healthcare companies that receive millions from NHS contracts. Yet, the researchers of the systematic review in the BMJ found only one paper they could include that looked at the effect of these companies in the UK, published in Age and Ageing in December 2022.

This study concluded that private equity financing and independent for-profit ownership is associated with lower quality in care homes and called for quality to be monitored as the care homes market structure was changing due to the influx of private equity.

An article from late 2022, on the website of RSM a leading audit, tax and administration company for the private equity industry, noted that the UK healthcare industry offers "rich pickings for PE investors large and small" and that "political pressure to relieve NHS backlogs will benefit businesses that can bring down waiting lists," and these are attracting private equity investment.

Notable recent deals include: the sale of Virgin Care, primarily a community healthcare business, to Twenty20capital in 2021 and its subsequent rebranding as HCRG Care Group; the 2021 acquisition of the mental health provider Huntercombe Group and merger with Active Care Group by Montreux Healthcare Fund based on the Isle of Man; and the December 2020 acquisition of The Priory Group by Waterland, a Dutch PE group, which in 2021 alone received £626.8 million from the NHS and social services.

Insourcing takes off despite NHSE opposition

An international private equity firm has bought up a UK-based agency that employs NHS doctors and nurses outside their contracted hours – to do "insourcing" work in NHS hospitals, reports the Financial Times.

The agency, Birmingham-based Medinet, claims to help NHS organisations reduce waiting times, but NHS England "strongly discourages" the use of insourcing because it "doesn't provide any additional staff," but increases costs. Its guidance states

"NHS England and NHS Improvement strongly discourage the use of insourcing solutions where temporary workers are paid escalated rates and where approved frameworks are not used.

"The reason for this is because it often does not provide access to additional workforce, rather escalated pay rates attract workers from elsewhere. This reduces the supply of agency workers available to fill shifts elsewhere in the trust and wider health system, and has a ripple effect on general agency rates, as it raises the pay expectations of agency workers, and forces other departments and trusts to increase their rates to attract their workers back."

Of course the fact that there is a market for Medinet and around 20 other organisations offering staff for "insourcing" flows from chronic staff shortages in the NHS, and the failure of NHS England's price caps (which don't appear to have changed since 2020) to offer attractive rates for overtime and bank working. Private equity firms have been scenting quick profits to be made.

The FT reports the results of freedom of information requests by consultancy Candesic that show the NHS spent £55m in 2022 employing its own staff to do extra work through specialist agencies. And while this total was down from £62m the previous year, Medinet's income of almost £59m last year was a 93% increase on the previous year.

The agency was bought up for an undisclosed sum by Fremman Capital, while another insourcing firm 18 Week Support, was bought last year by US private equity firm Summit Partners.

Private equity targets short term profits: the fact they are nosing round this sector shows these profiteers are banking on continuing failure of government and NHS trust bosses to resolve their staff shortages.

John Lister

Why are consultants and radiologists striking?

The NHS has seen a wave of strike action in 2022/23 – nurses, junior doctors, and most recently in July 2023 consultants and radiographers .

Consultant doctors and hospital-based dentists took strike action for 48 hours from Thursday 20 July until 7am Saturday 22nd. More than 24,000 consultants voted in the BMA ballot for industrial action last month, 86% of whom voted in favour.

On 25th July, the Society of Radiographers took strike action on their own for the first time in its 103-year history. Across England, thousands of radiography professionals started 48-hours of industrial action in order to make their voices heard.

Although the media has focused on the pay demands, the strike is about so much more, including the safety of patients in the NHS, staff shortages, and difficult working conditions.

How much has been offered?

The government has offered the consultants a pay rise of 6% and the radiographers only 5%.

Both the BMA and the Society of Radiographers have described the offers as "derisory". The BMA noted that consultants have seen real-term take-home pay fall by more than a third (35%) over the last 14 years. The Society of Radiographers also noted that although radiographers work considerably more than their contracted hours, their pay has faced real-terms cuts since 2008.

But aren't consultants paid very well already?

The government, and much of the media, has painted consultants as all being in receipt of large six figure salaries, however this is not the case. Consultants in England earn between £88,364 and £119,133 as a base-rate. With added over-time and on-call work, consultants can earn more.

The workforce crisis means that consultants now have to work longer hours to fill the gaps in the workforce, which in turn increases the likelihood of burn-out.

This then leads to consultants looking for jobs elsewhere with a better work-life balance for more pay.

Although some consultants do also work in the private sector, many do not.

Dr Ben Hockenhull, a consultant anaesthetist at UCH, notes that: 'They [the media] use figures that include overtime, which we're getting because we are working to fill in gaps because there aren't enough of us on a regular basis'.

The BMA has published data that shows that the pay of consultants in England flatlined at just 14% growth in the 14 years to 2022/23. It notes that in contrast, the average pay for the UK went up by around 48% in the same period and those in the professions such as law, accountancy, financial services, architects and engineering, enjoyed growth of nearly 80% in wages.

The BMA notes that the analysis shows that consultant pay

has both failed to keep up with inflation and failed to keep up with comparable professions.

The Chair of the BMA Consultants Committee, Dr Vishal Sharma said: "This dispute is not just about one year's pay settlement, it is about the reality of 14 years of consultant pay falling behind, about a loss in our pay in real terms of 35% and the broken pay review system that has allowed this to happen. There is absolutely no justification for the wages of some of the country's most senior doctors to not have kept pace with those of comparable professions."

Dr Vishal Sharma, from the British Medical Association's UK consultants committee, told a gathering at the BMA headquarters, that while consultants were no doubt paid more than average, "You have to look at the context, the level of training and the level of responsibility that we hold, making hundreds of decisions a day that impact on people's lives."

What else is the strike about?

Consultant oncologist Lucy Gossage, published an article on why they were striking, which excellently outlines the issues faced by consultants today due to a lack of staff and investment in resources.

The article noted:"I'm striking because so many of our workforce are burnt-out. The pressures of working in an overstretched service, balancing impossible demands, apologising for a failing system and knowing that, despite our best efforts, we're not delivering our patients the service they deserve is soul destroying."

The NHS has thousands of vacancies for doctors and radiology professionals.

The drain in staff means that services are often not fully staffed, staff are having to take on more work to cover the gaps in the rota, and that creates stress and adds to the high levels of burn-out in the NHS.

Dr Shanu Datta, a consultant psychiatrist in Preston and deputy chair of the BMA consultant committee, told The Guardian:

"I speak as a consultant psychiatrist, and looking back over the past 10 years, I struggle to think of a time when my organisation was ever fully staffed with consultants. This is because we are one of the most under-doctored economies in the western world, and that inevitably has a bearing on staff morale. We are seeing colleagues with significant amounts of exhaustion and burnout."

The Society of Radiographers (SoR) reports that one in 10 radiography jobs are unfilled and one million people are on NHS waiting lists for radiography services. Dean Rogers, the executive director of industrial strategy and member relations for the SoR, said: "We need to draw attention to the fact that many radiography professionals are feeling burnt out by low pay and increased hours. They're leaving the NHS, and they are not being replaced in adequate numbers."

"If the government wants to reduce NHS waiting lists and ensure that patients receive the treatment they need, when they need it, then it must urgently prioritise the recruitment and retention of radiography professionals – and that means talking to us about pay and conditions."

The Royal College of Radiology has reported that in almost all UK cancer centres patients' treatments are being delayed due to staff shortages.

Nick Lowry, a therapeutic radiographer in Bristol said the strike is the result of the government "kicking the can down the road".

"That's a combination of not recruiting enough staff, not paying them correctly, not providing enough funding to the NHS and specifically to radiographer services".

What do the consultants and radiographers want?

The BMA's consultants committee is calling on the government to present a credible pay offer for consultants in England.

The committee has previously indicated it would accept the same above-inflation pay deal – a 12.4% rise – offered to junior doctors in Scotland.

A BMA report on the pay review committee for doctors and dentists in the NHS shows its lack of independence with years of government interference, which has led to the erosion of pay for NHS staff. The BMA wants the government to commit to meaningful reform of the broken pay review process

The SoR wants the government to meet and agree on an immediate plan which includes: a good starting salary to attract trainees; pay restoration over a reasonable time to retain colleagues; and an end to the long-hours culture and dependence on expensive agencies.

The SoR has called on the government to re-open the NHS 2023-24 pay round after the latest rises for public sector workers outstripped the earlier 5% awarded to radiographers in England.

What is the government doing to solve the dispute?

The Health Secretary, Steve Barclay met the BMA Consultants committee once in February, and has not met them since the consultants voted overwhelmingly for strike action in a ballot last month.

Before the strike the SoR reported that it is willing to meet the government, but the government has refused to meet them. Steve Barclay, has said the pay award for radiographers was final.

As the strike ends Dean Rogers, executive director of industrial strategy and member relations, has sent a letter to the health secretary, Steve Barclay, inviting him to meet to discuss ways of tackling the recruitment and retention problems besetting the profession.

Vishal Sharma, chair of the British Medical Association's consultants committee, has said that consultants will not back down in their pay dispute and warned of further strikes next month unless the government offers "meaningful talks" on a settlement..

What are virtual wards? How are they being used?

The current government and NHS England view 'virtual wards' as a panacea for the lack of capacity in the NHS. The end of July saw NHS England setting out its plans to avert the winter crisis in the NHS, part of which is a rapid increase in the number of virtual wards.

And earlier this month, NHS England announced its virtual ward programme would be expanding to children, with overall virtual ward bed numbers expected to hit an ambition of 10,000 by the end of September.

Virtual wards were the centrepiece of the government's delivery plan for recovering urgent and emergency care services announced by the Department of Health and Social Care back in February 2023.

The plan includes virtual wards to treat up to 50,000 elderly and vulnerable patients a month at home by the end of 2023-24.

What is a virtual ward?

Virtual wards have been under development for several years, but the Covid-19 pandemic accelerated their development.

A virtual ward allows the NHS to support people at home, or in a care home using technology, such as remote monitoring apps, wearables and medical devices, however support may also involve face-to-face care from a multi-disciplinary team based in the community.

The acceleration of 'virtual wards' for Covid-19 patients was due to clinicians realising that some patients with Covid-19 were arriving at hospital too late as they were not aware of having very low blood oxygen levels until they felt extremely unwell. This re-

sulted in some patients needing invasive treatment and/or being admitted to intensive care units, and in some cases even dying. If they had known earlier about their oxygen levels then they could have been treated at an earlier stage.

The Covid-19 virtual wards use pulse oximeters to monitor oxygen levels. In England, two models were used: pre-hospital, in which patients were referred via community routes and post-hospital, in which patients were referred upon early discharge from hospital.

'Virtual wards' now cover a variety of conditions, including cardiovascular and respiratory problems, such as chronic obstructive pulmonary disease (COPD). In December 2021 NHS England published guidance for setting up a frailty virtual ward for those with frailty aged 65 or over who have an acute exacerbation of a frailty-related condition and updated guidance for virtual wards for acute respiratory infection, which expands on the guidance for Covid-19 virtual wards.

Analysis of Covid-19 virtual wards has found that they assisted with earlier discharges and reduced clinically necessary re-admissions for patients admitted with COVID-19, saved money but without compromising on patient safety.

The new plans from the DHSC are primarily focused on frail and vulnerable patients with the creation of more "urgent community response teams" to provide patients with at-home support "within two hours". There will also be an expansion of the frailty and falls service. Since the February 2023 plans, virtual wards plans have been expanded to paediatric care.

How many virtual beds are planned?

The targets for virtual bed numbers are not new; they were set back in February 2022 in NHSE's 2022-23 planning guidance. This gives the target of 40 to 50 virtual beds per 100,000 population by December 2023, and this was backed with £450m in funding over two years.

This is between 22,400 and 28,000 virtual beds across England, an increase of around ten times the estimated 2,500 virtual beds in place in December 2021. According to the new plans the target of 40-50 virtual wards per 100,000 people, will allow more than 50,000 admissions a month.

By December 2022, 7,000 virtual beds were reported to have been delivered. The February 2023 announcement plans for another 3,000 to be available by Autumn 2023 taking the figure up to 10,000.

However, uptake of the virtual beds has been slow. Of the 7,000 opened by December 2022, only just over half had been actually occupied. In December 2022 HSJ reported that NHS England director for community transformation Stephanie Sommerville told a NHSE webinar that occupancy stood at around 52% (3,602 of the 6,944 beds). HSJ was then told by NHSE sources that this has now increased to around 55%. And HSJ noted that it had seen internal figures that said just over half of the 7,000 new virtual ward beds opened under the new national programme are occupied by patients.

Are there enough staff for the plans?

The NHS has a staffing crisis with many thousands of vacancies. Whilst patients in virtual wards do not need hospital staff feeding and washing them, they still need trained staff to analyse information received from the technology and staff to respond if the technology says an intervention is needed.

There are numerous devices and technology platforms now available for virtual wards, but despite the presence of technology, the Nuffield Trust, in an overview of virtual wards, noted that there is still the need for an element of human contact and sufficient staff to make the wards a success.

The British Geriatrics Society (BGS) welcomed the increase in virtual wards but noted that the "biggest challenge" will be ensuring that appropriately trained staff are in place to provide services. The BGS noted that "the NHS faces record workforce shortages and simply moving staff around from one part of the NHS to another can only work as a short-term fix."

The workforce issue has also been highlighted by The Royal College of Nursing director for England Patricia Marquis who said: "More hospital beds and more community and social care services are desperately needed to ensure patients get the right care in the right place at the right time. But the real problem is the lack of staff. Extra beds are only safe when there are enough nurses for the patients in them. And because of the workforce crisis, existing services are unsafe."

In May 2023, a report on virtual wards from the NHS Confederation noted that the "steady lack of available workforce over the years continues to affect the feasibility of delivering virtual wards at scale."

As well as the issue with a lack of NHS staff, there is the additional issue of lack of social care staff as without support from this area in the community, it is difficult to see how virtual wards in particular for elderly patients with frailty will succeed. In October 2022, there was a vacancy rate of 14.1% in social care, with 165,000 vacancies, up 52% over the previous year.

How will the virtual wards be funded?

The original guidance published in February 2022 for around 25,000 beds by 2023/24 was backed by two-years of funding of £450m, which according to the guidance, is expected to be spent on "workforce pay costs (including clinical, operational, administrative and programme delivery resource) to fund the staffing models required for virtual wards."

There is no new money for the more recent announced expansion of virtual wards. The new plans, the expansion of virtual beds plus the additional 5,000 permanent hospital beds and 800 new ambulances, will have to rely on £1bn of funding previously announced in the autumn statement. In addition, there will be around £1.6bn already allocated to social care to be spent on initiatives to speed up discharge of patients from hospital.

The February 2022 guidance noted that the money (£450mn) ends after two years and: "No ring fenced 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."

The NHS Confederation has noted that "Investment in virtual wards need to be long-term and flexible" as "short-term funding models are hindering recruitment, planning and impact assessment of virtual wards." They also noted that the lack of adequate funding for social care is "preventing systems from fully addressing the holistic and wrap-around needs of patients away from only clinical virtual ward support."

Are they appropriate for all patient groups?

Virtual wards now cover a variety of conditions, including cardiovascular and respiratory problems, such as chronic obstructive pulmonary disease (COPD). In December 2021 NHS England published guidance for setting up a frailty virtual ward for those with frailty aged 65 or over who have an acute exacerbation of a frailty-related condition and updated guidance for virtual wards for acute respiratory infection, which expands on the guidance for Covid-19 virtual wards.

The success of three pilot virtual wards for children, in Blackpool, Dorset, and Dudley, which have treated 6,400 children over 12 months, has led to the expansion of virtual wards to cover children in every region of England from July 2023.

The BGS notes that "Among the various virtual ward models being developed by the NHS, it is Hospital at Home for older people with frailty which is most likely to make a difference. Research has shown that this type of care can enable some people to receive hospital-level care where they live, with equivalent health and wellbeing outcomes as would be expected if they went into hospital."

Analysis of Covid-19 virtual wards has found that they assisted with earlier discharges and reduced clinically necessary re-admissions for patients admitted with COVID-19, saved money but without compromising on patient safety.

However, other evaluations of virtual wards have highlighted issues, predominantly around the engagement of certain patient groups. Some patient groups had more difficulty engaging with the service than others, for example, those with a disability, older adults, and ethnic minorities, and there were also patient factors (such as knowledge and physical health), and having enough support from staff and family members or friends, that affected engagement in the virtual ward.

The Royal College of Physicians are concerned that the setting of targets for virtual wards by NHSE is leading to low-risk patients being placed on virtual wards, when they do not need monitoring. The Royal College of Physicians described the 10,000 target as "not helpful".

RCP clinical vice president John Dean told HSJ: "There is a need for increased community care for a number of patients who remain at home. But we mustn't be over treating and over monitoring patients who would not otherwise have been in hospital in order to count the numbers and fill NHS targets. The 10,000 virtual beds is not a helpful target, because we're focused on counting, not in delivering hospital level care at home."

There is also the problem of health inequalities. Not everyone lives in a warm, dry home, with their own bedroom, a modern mobile phone, and access to fast, reliable broadband. Virtual wards could potentially provide patients with internet connectivity and hardware devices, but it would not be possible for the digital devices to solve the problem of inadequate heating, mould and cramped accommodation.

Opportunities for privatisation?

Provision of 'virtual wards' across England is set to be create another opportunity for independent providers to gain NHS contracts.

In the NHSE's published guidance in April 2022 to Integrated Care Systems, commissioners of services are reminded that:

"Given the independent sector is already a valued partner in many local health and care systems, as providers of a range of NHS healthcare services, the delivery of virtual wards is an opportunity to build on these relationships.

"Partnerships with independent sector healthcare providers (ISHCPs) may expand local capacity and enhance capability through strong local partnerships with existing acute and primary care providers"

The commissioners were also reminded that the independent sector should be considered as both a provider of healthcare and of technology for the virtual wards.

To date it is the technology developers, an area not covered by the NHS, that are reaping the benefits of this push to virtual wards. Companies, such as the UK start-up Doccla, and Spirit Health.

Virtual wards have a lot of positives and technology is available now that has expanded their use to many different situations, however their success is not a given if the government continues to ignore the issues of workforce and training..

Sylvia Davidson

NAO tries to make sense of New Hospitals Programme

The key Tory manifesto promise to build 40 new hospitals by 2030 was always implausible to all but the most gullible fans of Boris Johnson: but now a new report from the National Audit Office has confirmed that there is no chance of the pledge being fulfilled..

It states that just 32 new hospitals "according to [the government's original definition] might be completed by 2030, with a further eight to be completed later.

At most two of the very smallest schemes might be completed by 2025.

One, of these, the £20m Dyson Cancer Centre in Bath, partly funded by donations from a charity and from the vacuum cleaner magnate Sir James Dyson, is scheduled to include just 22 beds: the other, a new community hospital at Shotley Bridge, which the NAO categorises as a red risk and yet to complete a business case, will be a combination of outpatient facilities with just 16 beds.

Any schemes ready?

None of the six major schemes initially presented as shovel ready back in 2019 (replacing Princess Alexandra Hospital, Harlow; Watford General Hospital; Whipps Cross Hospital, part of Bart's trust in East London; a new Specialist Emergency Centre for Epsom & St Helier trust in South West London; reconfiguration of University Hospitals of Leicester; and a new wing for Leeds General Infirmary) has even completed a business case.

These schemes, which were at first expected to be completed by 2025, along with two others are now in 'cohort 3', "expected to complete by mid 2030". The NAO estimates the combined cost of these schemes alone as ranging from £5bn-£10bn.

Other projects have also been grouped by the New Hospitals Programme (NHP) into "cohorts," and where possible the NAO has attempted to estimate the percentage increase in costs for each cohort since funding was allocated to them back in 2020.

Cohort 1 is almost entirely composed of projects planned and in progress before the 40 new hospitals pledge was made. Its combined cost is now estimated at £2.7bn. It includes the completion of the two major Private Finance Initiative hospitals that were left stranded in early 2018 by the collapse of Carillion, Royal Liverpool (eventually completed last year and operational) and Midland Metropolitan in Birmingham (now not due to open until October next year, with costs having soared by 67% since 2020).

Cohort 2 is a collection of ten relatively smaller schemes ranging in cost from "less than £50m" to £300m. Among the most dramatic increases in projected costs are the doubling in cost of the new Women's and Children's hospital at Treliske in Cornwall (up 103% to £300m) and the bigger percentage increase in cost of Derriford Emergency Care Centre in Plymouth (up 137% to £200m). None of the business cases have so far been approved.

How many by 2030?

But the worst-placed are the 14 schemes on Cohort 4. The NAO expects only eight of them to complete construction … after 2030. The total estimated cost of these schemes ranges from £9bn-£19bn. One of the known losers from this group is Imperial College Healthcare Trust in North West London, facing a massive backlog bill for maintenance, whose two major projects, rebuilding St Mary's Hospital Paddington (upwards of £2 billion) and fully refurbishing and new build at Charing Cross and Hammersmith Hospitals (£1bn-£2bn) have both been told there will be no funding until after 2030.

It is curious indeed that the NAO report, despite being a whole year in the making, misses out a number of important developments, and indeed fails to address a government announcement on the funding of the New Hospitals Programme just a few weeks before publication.

With ministers having agreed to just £20bn of capital funding for the NHP by 2030, rather than the £35bn cost of the full list, Health & Social Care Secretary Steve Barclay confirmed at the end of May that eight schemes were being postponed until the next decade (St Mary's/Charing Cross/Hammersmith Hospitals (Imperial); Queen's Medical Centre (QMC)/Nottingham City Hospital; Royal Preston Hospital; Royal Lancaster Infirmary/Furness General; East Sussex Hospitals; Hampshire Hospitals; Royal Berkshire; and North Devon District Hospital.)

The NAO timeline strangely makes no mention of this, or various other early warnings that the whole scheme was going badly wrong, even though these were revealed by the Health Service Journal and in some cases by the national and local press.

Nor does the report chart the many twists and turns in the way the promise of 40, then 48 "new hospitals" (and the very definition of a 'new hospital') has repeatedly been spun and revised by ministers and DHSC comms staff.

Indeed the NAO has little information on anything prior to the summer of 2021. It fails to note or question the inclusion in the autumn of 2020 of two additional major projects (rebuilding Hillingdon Hospital and North Manchester General) into a new list of eight "pathfinder" projects (now Cohort 3), but without increasing the allocation of capital.

The NAO also seems oblivious to the July 2021 warning given by the head of the New Hospitals Programme (NHP) Natalie Forrest, who admitted to a conference that the 'brakes had come on' for some of the pathfinder projects, and raised concerns over the capacity of the construction industry to complete so many projects by 2030.

It makes no mention of the letter sent by the NHP at the end of July 2021 to all eight "pathfinder" trusts calling for them to draw up cheaper plans, asking them to submit three sets of plans for evaluation – including an option costing no more than £400m, along with their preferred scheme, and options for building the project in phases.

All of the five schemes that had published costed plans were initially estimated at more than £400m, and the others are likely to be at least as costly.

Nor does the NAO examine the costs and wasted effort by trust boards that drew up a total of 128 bids in the hopes of becoming one of just eight additional funded schemes to make up the revised 48 'new hospitals,' an exercise which is completely ignored in its review.

Five of those eight places have now been taken by bids to rebuild hospitals entirely constructed between the 1960s and the 1980s from unstable unsafe 'reinforced autoclaved aerated concrete' (RAAC). These are now in theory included on the list for new buildings. However the NAO notes the estimated average cost of these is £1 billion each, and neither the plans nor the funding required have yet been signed off.

However the NAO does raise concerns that work since 2022 on a smaller, cheaper "minimum viable product" (MVP) version of its standardised design for a new hospital ('Hospital 2.0') will result in hospitals that are too small. One specific concern that is highlighted is the NHP's assumption that the new hospitals could operate at a target 95% occupancy, and that length of stay could be reduced by a hefty 12% to increase the numbers of patients using each bed.

The NAO points out that not only is there little evidence of the achievability and desirability of the reduction on length of stay, but: "England already has one of the highest rates of bed occupancy and one of the shortest lengths of stay per patient in the Organisation for Economic Co-operation and Development (OECD). Currently, 95% occupancy is viewed as highly undesirable and indicative of crisis, and NHS England has a priority to reduce it to 92% across the NHS in 2023-24."

The NAO concludes that at most just 32 hospitals in England classed as 'new' by the definition the government first used could be completed by 2030.

Worse, it appears that the New Hospitals Programme has already managed to spend £1.1 billion of the £3.7bn that has been allocated to the rebuilds, without commencing work on any major project, and the NAO argues that what they have done so far does not represent value for money.

The NAO also expresses frustration at the failure of the NHP to explain any rational basis for their selection of some schemes and exclusion of others. It urges a change in future decision-making: "When it makes decisions about where to build new hospitals in future, DHSC should appraise options in a transparent way using the best evidence available and should keep full records of why it selects specific projects."

Rising costs and backlogs

In what is likely to be a serious under-statement of the wider problem of 13 years of inadequate capital investment in the NHS, the NAO points to the consequences of under-investment in what should be routine maintenance of hospital buildings and equipment, noting that the combined backlog has rocketed in real terms from £4.7bn in 2013/14 to £10.2bn in 2021/22.

At the last count 22 hospital trusts in England were facing backlog maintenance bills in excess of £100m, and many more have postponed vital work because of unaffordably high costs. It's likely these numbers will increase once more when the updated data are published in October. An ITV News report recently revealed that nearly half of NHS hospitals in England have been forced to close wards and vital services due to flooding, power cuts and structural problems.

A modest promise of a handful of small "new hospitals" at some point in the next decade is unlikely to compensate in the public view for the continued decline and dilapidation of hospital buildings and equipment.

But after 12 months of waiting for the NAO report many of us will have expected them to deliver a more thorough and wide-ranging review of the overwhelming chaos and failure to deliver on one of the government's key promises.

John Lister

Explainer: key points of the long-term workforce plan

After many years of waiting, the long-term workforce plan for the NHS has finally been published, so what exactly does it promise for the NHS and its staff?.

The 151 page document sets out how the NHS is going to train thousands more doctors, nurses, and other healthcare workers to fill the current vacancies in the NHS (currently around 112,000) and to provide staff for the predicted increase in demand over the next 14 years.

The government projections are for the number of people over the age of 85 to grow by 55% by 2037, and this risks a shortfall of NHS staff of between 260,000 and 360,000 by 2036-37.

A plan is badly needed if the NHS is to fill these vacancies with NHS-trained staff and move away from employing agency workers at high rates of pay and raiding other countries' health-care systems for staff.

If the plan is successful, the government believes the NHS will have 300,000 extra doctors, nurses and other health pro-

fessionals by 2037. The key to achieving this is, according to the government plan, training, retention and reform.

Increased training places

Over the next 14 years the plan is for an increase in the traditional training routes for doctors and nurses, but also a big expansion in apprenticeships. The plan mentions that the latter routes should open up opportunities for people from under-represented backgrounds in healthcare.

For doctors, the number of places in medical schools each year will rise from 7,500 now to 10,000 by 2028 and 15,000 by 2031, with a focus on specialties where there are too few doctors.

There is also a massive shortfall in GPs and training places will increase by 50% to 6,000 by 2031/32, although the first 500 new places won't be available until September 2025.

For nurses, the plan is for a big expansion in adult nursing training places, taking the total number each year to nearly 28,000 by 2028-29 and nearly 38,000 by 2031-32. The broader plan is to increase the number of nursing and midwifery training places to about 58,000 by 2031-32.

One of the major changes in how NHS staff will be trained is a large expansion in apprenticeships, with a goal that 22% of all clinical training will be done through this route by 2031/32, up from 7% at present.

Medical degree apprenticeships will be introduced, with pilot schemes running in 2024/25, with an aim for places to increase to more than 850 by 2028/29.

There are plans to expand dentistry training places by 40% so that there are more than 1,100 annual places by 2031-32, and possibly to introduce a tie-in period requiring dentists to commit to working for several years for the NHS after graduation.

Training more NHS staff domestically is intended to reduce reliance on international recruitment from nearly a quarter of staff at present to about 10% of the workforce.

How will staff retention be improved?

This is a major issue in the NHS. After years of training staff either leave to work in healthcare systems elsewhere, such as Australia, go part-time, join an agency to then work for the NHS, or leave healthcare entirely. The goal is for 130,000 fewer staff to leave the NHS over the next 15 years.

The reasons staff leave include pay, burn-out, lack of flexible working, and the culture in certain sections of the NHS, such as bullying and racism.

The actions in the plan on improving retention lack detail, but mention improvements in flexible working and access to health and wellbeing services. Plus funding professional development and supporting working parents with extended childcare support.

Recently retired consultants will be targeted for work in the NHS via an NHS Emeritus Doctor Scheme and there are plans to improve flexible opportunities for those about to retire. Modernisation of the NHS pension scheme is also part of the plan.

Most notably, what is not mentioned is any improvements in pay, the subject of the ongoing strike action in the NHS.

What reform is planned?

The section of the plan focused on reform, talks of innovative ways of working and new roles within multidisciplinary teams, and changes to training. The way services are delivered is targeted for reform with mention of digital and technological innovations, including the use of AI.

The new roles of nursing associates (NA) and physician associates (PA) will see training places increase. NAs to 10,500 by 2031/32 and PAs to over 1,500 by 2031/32. The plan is for there to be over 64,000 NAs in the NHS and around 10,000 PAs by 2036/37.

The plan aims for a greater focus by the NHS on preventative and proactive care, moving more care into the community. To enable this, there is an ambitious target of growing the number of staff working in mental health, primary and community care by 73% by 2036/37.

A more controversial change in training will be medical schools being asked to shorten their degree programmes, from the current five or six year degree programmes to four years. There will also be a pilot medical internship programme. The government wants students to move into the workforce earlier in their training to boost staff numbers. There have also been plans for nursing students to begin on the wards six months earlier than at present.

How will it be funded?

The big question, how will this plan be funded? Well, the increase in training places for doctors, nurses, midwives and other health professionals will be funded by an extra £2.4bn over five years. After this there is no amount mentioned for funding of the continued increase in training as it will be the subject of political choices.

Other than the £2.4bn, the government is hoping there will be a labour productivity increase of up to 1.5-2%, brought about by "reducing the administrative burden through technological advancement and better infrastructure" and improving efficiency through reducing hospital admissions and using a broader range of staff.

The idea is also that the plan will generate some savings, for instance by reducing spending on temporary agency staff by £10bn.

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.

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