THE lowdown

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

Informing, alerting and empowering NHS staff and campaigners

RCP warns of vacancies

THE rate of unfilled NHS consultant psychiatrist posts has doubled in the last six years in England, according to a survey by the Royal College of Psychiatrists.

One in 10 posts are vacant, up from one in 20 in 2013.

Vacancy rates are particularly high in areas of mental health care prioritised by the Government for improvement, prompting fears that plans to transform services over the next 10 years under a major investment programme will fail.

They are also higher in some regions: in eating disorders, the vacancy rate for consultant psychiatric posts is 11% in the East Midlands (Trent), but soars to 17% in the South East and South West and 33% in the East of England.

Although access to children's mental health services in England is improving, only 35% of those who need it get treatment.

Earlier this year, a report published by the College found that people with eating disorders can wait up to 41 months for treatment, with adults waiting on average 30% longer than under-18s.

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

Private GP service sets sights on further NHS expansion

The app will see you now …

Paul Evans

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

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

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

Problems for CCG

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

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

However, changes announced in late September by NHS England and NHS Improvement will change this and have a significant effect on the way Babylon Health operates from April 2020 onwards when they come into force.

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

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

Financial burden

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

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

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

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

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

IN THIS ISSUE

■ **WHO WE ARE** – and why we need YOUR help to sustain The Lowdown - Back

■ **FAKE FORTY** 4 pages of background & analysis on promised new hospitals 7-10

■ **BLUE on BLUE** Shropshire's Tory MPs row over Telford hospital downgrade 10-11

■ **PFI R.I.P.?** A closer look at the new Health Infrastructure Plan 11

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

Watchdog finds another care home company in trouble

Sylvia Davidson

The care home company Advinia is under investigation by the Care Quality Commission (CQC) following concerns that the company is financially unstable, according to a report in *The Guardian*.

Documents leaked to the Guardian show that the CQC is concerned about the cash flow at the company and its ability to pay its debts.

In late August, the CQC warned over 150 local authorities in England and Scotland that Advinia was not cooperating in a financial investigation and the CQC could not give the company a clean bill of financial health. The local authorities now have to decide whether to use the company as a provider or not.

Advinia's 38 care homes look after around 3,000 elderly residents and employ 4,500 staff in England and Scotland. In April 2018, the company acquired 22 homes from BUPA and as a result became the 10th largest company in this sector in England.

The *Guardian* understands from the leaked documents that Advinia has been blocking the CQC from conducting an independent business review of its finances; the CQC has the legal powers to scrutinise a provider's accounts if it "considers that there is a significant risk to financial sustainability". If Advinia does not comply with the CQC request the company could lose its licence to operate.

The documents seen by the Guardian also show that the CQC was worried about the "competency and capabilities" of Advinia's finance department; the company has had four finance directors over five months of the summer.

The leaked documents say that Advinia has sent a letter to the CQC setting out its reasons for not cooperating, but the regulator insisted this did not provide "the necessary reassurance".

Inadequate

The CQC has also had concerns over several of the company's care homes in recent months. In October 2018, the Arncliffe Court home in Liverpool received a damning CQC report with a rating of 'inadequate, then in early 2019 the Burrswood care home in Bury and Barrock Court home, just outside Carlisle, both received bad reports.

Burrswood had fallen from 'good' prior to its acquisition from BUPA to 'requires improvement', whilst the Barrock Court home requires improvements in all areas. The CQC inspection of Barrock Court was prompted by concerns from health professionals.

Advinia was set up by Sanjeev Kanoria and his wife Sangita 20 years ago. Kanoria has numerous business interests globally, including the ownership of the Austrian Anadi Bank, which he acquired in 2013.

There have been concerns about the financial vulnerability of the care sector for many years.

The sector has suffered from austerity measures instigated in 2010 when government reductions in local

In 2017, a report produced by the Local Government Unit think-tank and Mears, one of the leading home care providers, concluded that the home care business was on the brink of collapse

government funding led all local authorities to cope with the funding crisis by reducing the fees paid to care providers in both the residential and the home care sector. Many companies in the residential care sector, in an effort to increase their profits, have resorted to complicated business models backed by private equity and are now reliant on risky financial structures.

This leaves them exposed to collapse, with damaging consequences for care home residents.

In 2011 this is what happened to Southern Cross, a large national care home provider which had 9% of the market nationally. The company's collapse risked the care of 37,000 people.

Other private companies took over the Southern Cross contracts, primarily Four Seasons. But by the end of 2017, Four Seasons, itself was on the brink of financial downfall. The uncertainty around the company was only relieved when it struck a deal with US private equity investors and deferred debt payment. In April 2019, however the company went into administration.

The debt that eventually brought down Four Seasons was estimated to be £500 million.

In November 2016, a report by OPUS found more than one in four care homes across the UK will be facing a financial crisis over the next three years; this means that more than 6,000 care homes could close if they are not rescued by a new owner.

In March 2019, accountancy firm BDO reported that more than 100 care home operators collapsed in 2018, taking the total over five years to more than 400. Its report warned that as homes closed many patients would have nowhere else to go but hospitals.

Financial instability is also a major problem in the home care market. In 2017, a report produced by the Local Government Unit think-tank and Mears, one of the leading home care providers, concluded that the home care business was on the brink of collapse; companies were either going bankrupt or pulling out of contracts.

More recently, in October 2018, the CQC took the unprecedented step of writing to 84 local authorities with concerns for the financial stability of Allied Healthcare and its ability to continue to provide home care services past 30 November 2018.

The CQC was concerned that Allied Healthcare would not be able to make a loan payment due at the end of November. The company was saved from going into administration by its sale to Health Care Resourcing Group for an undisclosed sum in December 2018.

For more details on the long-term care market see the overview on the NHS For Sale website.

Hints of possible bursary U-Turn

There is a possibility that some type of financial incentive will be reintroduced to try and increase the number of people choosing to train as nurses, according to a report in the HSJ.

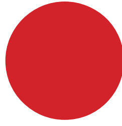
This would be a major U-turn for the government, which in 2015 removed the bursary system for trainee nurses. The removal of bursaries led to 10,000 fewer applicants in 2017, and nurse vacancies in the NHS have risen to over 40,000.

The Department of Health and Social Care is discussing with NHS England, Health Education England, and NHS Employers, which represents England's 240 NHS trusts, the possibility of bringing back cost of living grants of £3,000 to £5,000.

The financial inducements may also be expanded to other health professionals where there are major shortages, including paramedics and podiatrists.

The *HSJ* also notes that there has also been a suggestion that debts from doing a first degree could be written off.

Until bursaries were removed in 2015, nursing degrees attracted many mature students, who already had thousands of pounds worth of debt. Applications from mature students have now plummeted.



The target will be mature students and those specialising in mental health and learning disability nursing

If financial incentives are introduced, it is likely that that they will be restricted to certain groups, however.

The target will be mature students and those specialising in mental health and learning disability nursing; these two areas have major workforce shortages.

The idea has been welcomed by Chief Executive of the Royal College of Nursing, Dame Donna Kinnair, however she told The Guardian that it would take an injection of at least £1 billion a year into nursing education, through both tuition support and also help with living costs, to get back to the number of applications there were before 2015.

Lincolnshire health visitors' dispute escalates

More than 70 Lincolnshire health visitors are being balloted for strike action as the long running pay dispute escalates with county council bosses trying to 'divide and rule' over future job roles.

Unite said the new ballot would not only involve the health visitors who have been denied legitimate pay rises by the council since October 2017, but health visitors on the lower grade 9 and higher grade 10.

The ballot opens on Friday 11 October and closes on Friday 25 October.

They have already taken action on 32 days since July with the loss of around 450 shifts.

The dispute began over health visitors having lost more than £2,000 a year since they were transferred from the NHS, but Unite says it has now taken up the council's insistence on different contracts for grade 9 and grade 10 health visitors.

Unite argues that as all health visitors have the same community nurse qualifications, the same workplace training, and their role is equivalent to a grade 10 job role, and should therefore be graded and paid accordingly.

Unite regional officer Steve Syson said: "This dispute has now escalated due to the fact that the council has provocatively divided the health visitor role into two separate jobs.

Divide and rule

"This tawdry 'divide and rule' sleight-of-hand manoeuvre from this cash rich council, with a surplus of £188m for 2018/19, needs to be exposed.

"I hope all our members fully support this ballot, because, if they don't vote to take action, they will be accepting the division of the role and for those that don't move onto a grade 10 it will mean a loss of £4,000 per year, which is totally unacceptable."

Unite said that the county council's continual refusal to negotiate constructively since strike action originally commenced in the summer was having an adverse impact on Lincolnshire families with babies and young children.

"The council's blinkered action has already led to some of our very experienced members leaving their job to seek alternative employment where their qualifications are better respected and this drift will continue."

■ **The strikers have launched a crowd-funding appeal to help alleviate hardship.**

It's blue on blue conflict as Shropshire's MPs quarrel over Telford hospital downgrade

John Lister

Matt Hancock's decision to rubber-stamp highly contentious plans to downgrade Telford's Princess Royal Hospital, moving A&E and women and children's services to a new £312m hospital in Shrewsbury has brought the spectacle of local Tory MPs in total disarray.

Telford's Tory MP Lucy Allan, perched uncertainly in a seat which has a Labour council and now stands to lose its emergency hospital services, has oscillated between denouncing NHS "bureaucrats" and "highly paid hospital managers who thought they knew what was best for us," and blaming "the Welsh lobby" whose needs had been "prioritised over those of Telford".

She is now apparently living in denial of the impact of the decision that has been taken, and on the one hand bending the ear of the Health Secretary with advice to withhold the £312m to finance the new hospital unless Telford retains a 24/7 consultant-led A&E, and on the other looking to her hero Boris Johnson to step in, claiming rather incongruously that:

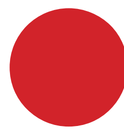
"The NHS is at the heart of this Government's domestic agenda …. **This is not a Government that will take much needed hospital services from former mining towns, with poor health outcomes, to move these services to the Tory shires**. … Future Fit is out of time and Boris Johnson must put a stop to it."

By contrast her neighbouring Tory colleague Mark Pritchard, in the adjacent Wrekin constituency has happily accepted Matt Hancock's decision to back the controversial Future Fit plan, arguing it's now time to "trust the medical experts" and claiming the Independent Review Panel "say ministers should keep their noses out".

However even Pritchard is not prepared to "trust the medical experts" on another Future Fit proposal – to shift women and children's services from Telford to Shrewsbury – which he says he will fight to stop.

Both of these Tories with counterposed views are focused on the central fudge in Hancock's decision: while giving the go-ahead to the reconfiguration plan, he baulked at the political impact of axing A&E services in Telford, which has a large, relatively deprived population with a growing proportion of over-65s. So he came up with a weasel phrase, which he hoped might defuse some of the anger:

"Having listened to and accepted the advice of independent clinical experts, I have asked NHS England to come forward with proposals within a month on how they will keep the A&E in Telford open as an A&E Local so that the Princess Royal Hospital can continue to deliver the urgent and emergency care the residents in the growing town of Telford need."



Without beds for the most serious cases Telford will not have an A&E: it could be dangerously misleading to suggest otherwise.

Evasive

Of course nobody knows what an A&E Local is: the phrase is used vaguely once in the NHS Long Term Plan, but no example exists.

Even when asked by the HSJ to explain, NHS England gave only vague and evasive answers, although it is clear that Telford cannot be both an urgent care centre AND an "A&E Local".

But the one thing local Tory MPs appear to agree on is building up a fanciful notion of the "A&E Local," seeking to convince local people that it really means A&E services will remain in Telford. Mark Pritchard declares:

"I am also glad the Department of Health has made it clear that Telford's A&E should be retained with a new state-of-the-art 'A&E Local' model. It incorporates the very latest cutting-edge thinking on how A&E care should be provided. This involves building on, and providing much more than the previously suggested Urgent Care Centre model. It means more consultant-led time at Telford. This is good news."

Lucy Allan began with questions, asking "What I want to know is what is an A&E Local and what this will mean for my constituents," but soon shifted to echo Pritchard's insistence it means effectively retaining the A&E department that Future Fit proposed to axe: "I am seeking 24/7 consultant-led A&E at Telford."

She went on: "The hospital trust has always been strongly opposed to this model and are continuing to resist this proposal.… It's wholly unacceptable that SaTH can choose to opt out of providing services in Telford at their discretion. They need to compromise. They cannot have it all their own way. The NHS is a public service."

However the Reconfiguration Panel's report that was accepted by Matt Hancock stresses repeatedly the need

Squeezing out Telford

The IRP report sets a worrying precedent, by accepting that once a Joint Health Oversight and Scrutiny Committee had been set up between Telford and Shropshire councils, the JHOSC became "the appropriate **and only** English scrutiny body with which the CCGs must consult on any proposals developed in respect of the Future Fit Programme."

The JHOSC has proved an effective way for Shropshire and NHS bosses to sideline Telford council and brush aside its concerns. NHS England was no longer required to keep Telford informed or deal with them directly at all.

So when Telford council argued in challenging the Future Fit plans that the consultation with the JHOSC was inadequate in terms of both content and time allowed, the IRP response was to dismiss the complaint because – not surprisingly – the complaint "was not endorsed by the JHOSC or the other party to the JHOSC, Shropshire Council."

to concentrate emergency services in a single site. Calling for the new model of hospital care to be "implemented without delay" the IRP pulls up well short of Hancock's ambivalent proposal for an "A&E Local" and stresses the limited urgent care provision at Telford:

"The Panel has previously commented about the confusion caused by the inconsistent use of names and models across the NHS and it is hoped that the current national policy to implement a standard urgent treatment model will improve matters. …

"Accepting the constraint that acute admissions will not be available at PRH, the Panel agrees that the aim should be to provide as much clinically appropriate urgent care and treatment as possible at the hospital."

However without beds for the most serious cases Telford will not have an A&E: it could be dangerously misleading to suggest otherwise. Indeed the "A&E Local" formula could cause problems and delays for patients who need to be admitted to a bed in Shrewsbury, but who would be in a "place of safety," and therefore not a priority as far as emergency ambulance services are concerned.

On a wider view, the IRP report is striking for its lack of any explanation of benefit to Telford's population from the Future Fit changes.

It contains no serious consideration of the needs of Telford's population which it admits has "higher than national rates of poor health with lower life expectancy and higher rates of people reporting long term limiting health problems or disability. Within the Borough, 15 areas are ranked in the 10 per cent most deprived nationally."

Campaigners' arguments rejected

Hancock and the IRP have now rejected the arguments of the Council and calls from Shropshire Defend Our NHS to retain both A&Es and expand community services.

But there are many more stages to go through before any new build, not least resolving what is meant by an A&E Local, and addressing the affordability gap of £100m or so between the plan and the £312m available.

The Shrewsbury & Telford Hospital Trust will need to develop a new 'strategic outline case' for the changes setting out how the money will be spent: once this is agreed the trust must then develop an outline and then a full business case before making its planning applications for any physical changes made to hospitals in Shrewsbury and Telford.

During this process there could be a legal challenge to the decisions that have been made.

Don't hold your breath waiting for a conclusion.

Compass staff strike again

Around 300 staff employed by private contractor Compass within NHS trusts in St Helens and Blackpool have also taken three days of strike action – angered by the company's failure to match health service pay rates and working conditions.

UNISON has condemned Compass for silencing its workers, after the firm disciplined hospital workers at St Helens & Knowsley Teaching Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust who had spoken out about low pay. UNISON regional organiser Pat Woolham said:

"It's plain that Compass is aiming to silence the strikers and suppress staff in an attempt to force them back to work. But the strikers are united, determined and will take further action if necessary." The September action was the third round of action on the issue by these hospital workers.

● More strikes have been called for 14/16/18/20/22/24 October

CCG mergers still avoiding any public consultation

The chief officer driving through the merger of five CCGs in Norfolk and Waveney boasts in a letter to a local councillor of having had responses from 245 members of the public, giving an indication of how few people are being consulted on these changes across the country.

As ***The Lowdown*** has reported NHS England is stepping up the pressure for groups of CCGs to merge. And while one planned merger – of the six CCGs in Staffordshire – has now been formally scrapped after a majority of GPs in five of the CCGs voted to reject the idea, GPs in other areas appear to be much less savvy and proactive. In Norfolk and Waveney all member GP practices of the CCGs were asked to vote, and 91% of the votes cast were in favour.

Campaigners have argued that one of the reasons behind the drive to merge CCGs into such large units is to further minimise any local voice or dissent while controversial closures and downgrades of hospitals and services are pushed through, although few CCGs have any great track record of standing up for local communities.

In a grim reminder of the lamentable record of many local councils in fighting for local health services, all three Health Overview and Scrutiny Groups for Norfolk, Suffolk and Great Yarmouth and Waveney agreed with CCG bureaucrats a full "public consultation" was not required, and nodded through proposals to significantly reduce any local accountability of NHS services.

However unlike CCGs, council health and scrutiny committees (which retain powers which date back to the 1970s to delay and challenge changes in services) are comprised of elected members.

So despite their current feeble showing they could yet be made into a last vestige of local accountability in the event of any controversial changes in an increasingly monolithic and bureaucratic "integrated" NHS.

Quality Improvement is best done by health staff, not academics

John Lister

Staff in hospital departments, mental health and community services should be engaged in efforts to improve systems and the quality and efficiency of services.

This type of quality improvement (QI), or service improvement involves a study of the way systems work and may involve a study of alternative ways of organising: but is not "research" as understood by academics.

What the (research) papers say

Indeed it is important to resist the efforts by academics to turn quality improvement into an academic pursuit, or one carried out by specific separate QI departments and handed down to staff at the front line.

A recent BMJ 'essay' by a high-flying Cambridge academic, How to improve healthcare improvement is undermined from the outset by getting this wrong.

The author, Mary Dixon-Woods, appears to set off in a promising direction, warning of the inadequate focus on quality improvement, on learning from failures and seeking to ensure systems have "the preconditions for high quality, safe care: funding, staff, training, buildings, equipment, and other infrastructure."

But she goes on to question the effectiveness of quality improvement in improving quality – not by comparing the performance and outcomes of departments and trusts before and after initiatives have been implemented, but on the basis of an absence of randomised control trials.

US quality expert Don Berwick made clear back in 1996 that this was not a useful way to assess such work:

"When we try to improve a system we do not need perfect inference about a pre-existing hypothesis: we do not need randomisation, power calculations, and large samples. We need just enough information to take a next step in learning.

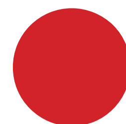
"Often a small series of patients or a few closely observed events contain more than enough information for a specific process change to be evaluated, refined, or discarded, just as my daughter, in learning to ride her bicycle, sometimes must fall down only once to learn not to try that manoeuvre again."

Much QI work takes place on a day to day basis within well-managed departments seeking to improve their performance, and is not written up into peer-reviewed academic papers.

The starting point must be what Berwick describes as the Central Law of Improvement: "every system is perfectly designed to produce the results it achieves".

So if we want to improve the quality of care delivered, we have to improve the system, and address any gaps, delays, confusion and other weaknesses that impede or undermine patient care.

Moreover if a quality improvement exercise results in a reduction in hospital-acquired infection – perhaps by improved and more frequent cleaning of doctors' stethoscopes, for example, or similar measures – there is no sense in then adopting a randomised control trial in which some patients are put at greater risk by research in which some doctors act as the "control" by not cleaning their stethoscopes.



Much QI work takes place within well-managed departments seeking to improve their performance, and is not written up into peer-reviewed academic papers.

The process for quality improvement advocated by Berwick, by the US Institute for Healthcare Improvement and by British advocates (including the 1000Lives Plus initiative in Wales) is the implementation in the workplace of a "plan-do-study-act (PDSA) cycle".

Berwick sums this up as inductive learning – "he growth of knowledge through making changes and then reflecting on the consequences of those changes."

He argues that "… the enterprise of testing change in informative cycles should be part of normal daily activity throughout an organisation."

If it's a part of normal daily activity, it's not academic research. Berwick says this method represents a democratisation of scientific method.

This is very different from the way academics seek to find a role for themselves and subject any area of inquiry to their own assumptions.

Ms Dixon-Woods argues some QI efforts, "perversely, may cause harm—as happened when a multicomponent intervention was found to be associated with an increase rather than a decrease in surgical site infections."

Had this intervention adopted a PDSA approach it would have been stopped as soon as there was any evidence of harm being done.

She also cites a study by a team including Lord Darzi that attempts to assess peer-reviewed publications of PDSA cycles but which complains that they show an "inconsistent approach" but "does not conclude whether better application of the PDSA method results in better outcomes."

Academics are unhappy with an approach that shows academics and their methods to be unnecessary and even unhelpful.

Even Dixon-Woods admits that "not all improvement needs to involve a well defined QI intervention, and not everything requires a discrete project with formal plan-do-study-act cycles."

Indeed the second page of her essay is considerably more constructive than the first, noting that "many high performing organisations, including many currently rated as outstanding by the Care Quality Commission … use structured methods of continuous quality improvement.

"But studies of high performing settings … indicate that although continuous improvement is key to their success, a specific branded improvement method is not necessary."

She also criticises mental health and learning disability services for paying much less attention than acute hospitals to quality and safety improvement.

So the essay serves as a useful spur to discussion of how services can be improved for patients through the involvement of the staff who care for them and addressing systemic problems rather than individual skills and behaviour.

Some of the right answers are included for those who stay the course and plough through a first page which is littered with the wrong ones.

Looking closer at Johnson's "fake forty" hospital plans

John Lister

It has been hard to keep up with and evaluate the succession of announcements of new money for refurbishment and building projects that have emerged since the beginning of August.

The two major announcements were of £1.8 billion in capital to "upgrade outdated facilities and equipment" in early August, and the commitment at the end of September to provide another £2.7 billion to fund six new or refurbished hospital projects, with "seed funding" for another 34 postponed future projects – which will potentially cost another £10 billion or more – after 2025.

From the outset there has been scepticism on where the money is to come from. and whether or not more than half of the initial £1.8 billion for capital projects was new money at all: it was swiftly revealed that £1 billion of it was money already in Trust accounts, but which they were forbidden to spend by NHS England in a 20% cutback as recently as July this year.

King's Fund chief executive Richard Murray said it was "difficult to tell how generous the government is being, given a lack of clarity over how the schemes had been selected, and how the pledges fitted within the department's overall financial settlement."

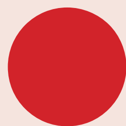
The Office for Statistics Regulation has since stepped in to call for more accuracy in ministerial claims.

It was only some time after this first initial announcement that any details emerged on what schemes were to result from the extra money, and a list of 20 was unveiled, totalling £850m.

They are a mixed bag, in which 3 primary care projects for almost £100m, two mental health projects totalling £112m and a new unit for Learning Disabilities for £33m were outstripped by 14 projects in acute hospitals – an imbalance that has continued in the subsequent announcements of "new hospitals".

The remaining £1 billion has now been released to be spent by trusts on the various projects that had been halted or cut back.

Some hospitals are promised future cash and new buildings: others like Weston are still facing cash-driven A&E closures



"The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year)."

Capital-starved NHS

Some of the process of claim and counter-claim over the figures will have conveniently distracted from the harsh fact that, as the Labour Party has pointed out, in excess of £4 billion has effectively been cut or siphoned out of NHS capital budgets since 2014, much of it used to prop up trusts' revenue budgets.

Indeed a hard-hitting campaign by NHS Providers, the body representing trusts, puts the figure even higher and calls for sustained increases capital funding for several years. They argue that:

"The NHS buildings and equipment budget has been relentlessly squeezed year after year. Over the last five years we've had to transfer nearly £5bn of that money to prop up day to day spending. As a result, the NHS now has a maintenance backlog of £6bn, £3bn of it safety critical. The NHS estate is crumbling and the new NHS long term plan can't be delivered because we don't have the modern equipment the NHS needs."

A more detailed NHS Providers briefing document published at the end of August, arguing the case for restoring and increasing levels of capital funding, raises the shocking fact that:

"The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year)."

It's not surprising therefore that while welcoming the promise of any extra money for new buildings, NHS Providers was less than ecstatic about the over-hyped claims to be giving an immediate go-ahead for 40 hospitals, and keen to emphasise what was still a vital missing element:

"The NHS has been starved of capital since 2010. There's a £6bn maintenance backlog, £3bn of it safety critical. It's not just these six hospitals who have crumbling, outdated, infrastructure - community and mental health trusts, ambulance services and other hospitals across the country have equally pressing needs. We also need increased capital spending to support changes in the way care is delivered, including in IT and digital, to deliver the new NHS long term plan."

Some of the projects appear to overlap with each other: a £99m scheme for a new children's hospital in Truro among the 20 projects funded in August, for

Continued next page

example, followed by inclusion of Cornwall on the list of trusts receiving "seed funding" for what was initially trumpeted as 40 new hospitals.

Then there was the 24 hours of uncertainty created by PM Johnson's off the cuff statement on September 30 at Conservative Party conference that a new hospital in Canterbury was to be included on the list of new hospitals, triggering all kinds of responses from confused local MPs and campaigners – only to find that no new projects in Kent were included at all.

Three lists of promises

So what has been agreed, where is the money going, and when, if at all, will the promised new projects begin to take shape?

There are three distinct lists of projects: the initial £1.8 billion (more than half of which has not been explicitly allocated); the list of six new hospitals given the "immediate" go-ahead; and the list of 21 trusts given a share of £100m of "seed funding" to work up projects to commence some time after 2025.

If these three lists are combined, the geographical distribution favours the **East of England** (11 projects) and the **North West** (10), in each case five of the projects allocated only "seed funding" and deferred to some time after 2025.

The **South East** is least favoured, being promised just 4, three of them post 2025 and one lump of £48m to redesign acute services on the **Isle of Wight.** The **North East & Yorkshire** region also has 4 projects, three from the £1.8 billion, and one of the more immediate projects – a development at **Leeds General Infirmary**.

Six of the seven projects announced for the **South West** are in the far future time frame beginning 2025.

The electioneering aspect of the proposals should not be forgotten either. Shadow Health secretary Jonathan Ashworth has also pointed out that **eight of the 21** future projects cover Tory marginal seats, where even a tenuous promise of a new hospital might win a few extra votes: he named **Hastings, Eastbourne, Winchester, Plymouth, Reading, Truro, Torbay, Barrow** and **Uxbridge**.

Backlog bills

A closer look at the allocations from the £1.8 billion shows that three of the major acute hospital trusts stand to receive sums that are only a small fraction of their backlog maintenance bill: for **Newcastle Hospitals** this was £116m at the last count, **Stockport** needed £94m and **United Hospitals of Lincolnshire** £78m. So even after the belated "extra" money is received each of these trusts will still face hefty and unpayable bills for repairs just to bring their buildings up to standard.

Wye Valley NHS Trust has finally been allocated the money to replace the 1940s-built hutted wards that should have been demolished as soon as the PFI-funded hospital in **Hereford** opened in 2002.

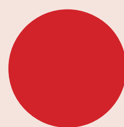
The relatively small sums included in this list also underline the extent to which trust finances have been squeezed in recent years, making even relatively modest projects and what should be routine maintenance and replacement of equipment unaffordable without additional support.

No instant start

Of the six new hospitals that have been given the immediate go-ahead, none is ready to start work for some months to come: most will takje much longer.

In **South West London** the long-running saga of the replacement of the crumbling **St Helier Hospital** in Carshalton that has dragged on for more than two decades is revived once again. Management of the **Epsom & St Helier** trust have decided the debate is about where to build a new £400 million "major acute" hospital.

Local people were once promised public money would be available to rebuild St Helier: but that promise was broken. Now they are promised Epsom and St Helier hospitals would both be retained as "district hospitals" – but a pale shadow of the current hospitals, with primarily



Eight of the 21 future projects cover Tory marginal seats, where even a tenuous promise of a new hospital might win a few extra votes

Nothing for mental health

Responses from the Health Foundation and NHS Providers to the funding announcements have flagged up ministers' focus on headline-grabbing voter-friendly acute hospital projects, and the grossly inadequate share of the new resources going to expand community health services, primary care and in particular mental health:

"None of the six hospital trusts given funding to develop a new hospital or the 21 trusts given seed funding in the government's health infrastructure plan, and just three of the 20 hospital projects which received funding earlier in the summer, are mental health trusts."

A new NHS Providers Framework for Community Mental Health points out the huge gap in provision that has opened up as a result of inadequate investment:

"Core community services are a fundamental element of mental health provision. However, they have suffered from a lack of investment in recent years which has significantly impacted the quality of services and people's access to them. Our report *Mental health services: addressing the care deficit*, found 85% of mental health trust leaders do not feel there are adequate mental health community services to meet local needs."

NHS Providers' analysis shows that the failure to prioritise investment in the mental health estate is having a real impact on patients:

The number of reported patient safety incidents caused by infrastructure (staffing, facilities, environment) in 2018/19 was 19,088 compared to 17,693 in 2017/18. "These incidents include unsafe environments with a risk to personal safety and inappropriate clinical environments."

The number of infrastructure incidents, such as inappropriate disposal of clinical waste or wards that are too hot or too cold, in mental health trusts has increased by 28% from 2015/16 to 2018/19, compared to a 16% increase for incidents in all trusts.

There were seven never events reported in mental health trusts in 2018 as a result of a shower/curtain rail failing to collapse and one as a result from a fall from a window.

Trusts allocated money from from £1.8 billion for upgrades & new equipment

NHS organisation	Acute hospital	Mental health & LD	Primary care
Luton & Dunstable University Hospital	99.5		
Norfolk & Norwich University Hospitals	69.7		
Norfolk and Suffolk NHS FT		40	
NHS South Norfolk CCG			25.2
University Hospitals Birmingham	97.1		
United Lincolnshire Hospitals Trust	21.3		
Wye Valley NHS Trust	23.6		
University Hospitals of North Midlands	17.6		
Barking, Havering & Redbridge CCGs and NE London NHS Foundation Trust			17
Croydon Health Services NHS Trust	12.7		
South Yorkshire and Bassetlaw Integrated Care System			57.5
The Newcastle upon Tyne Hospitals NHS Foundation Trust	41.7		
Leeds Teaching Hospitals NHS Trust	12		
Greater Manchester Mental Health NHS Foundation Trust		72.3	
Mersey Care NHS Foundation Trust		33	
Stockport NHS FT	30.6		
NHS Wirral CCG	18		
Tameside and Glossop Integrated Care NHS Foundation Trust	16.3		
Isle of Wight NHS Trust	48		
Royal Cornwall Hospitals NHS Trust	99.9		
Totals	608	145.3	99.7

Dr Neil Clifton, CC BY-SA 2.0, https://commons.wikimedia.org/

St Helier Hospital in Carshalton SW London in 2012: the banner boasts a new hospital is "coming soon"

outpatient and diagnostic services, an urgent treatment centre – and little more than half the 748 'core beds' that were available in Epsom and St Helier earlier this year. An 'Issues' document last year stated that "any potential solution with more than one major acute site … is eliminated".

Local health chiefs now have to run a full public consultation in which they state where the new hospital should be, followed by development of a full business case. This story could run and run.

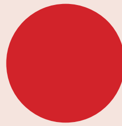
In **North East London** the announcement that the money is available will relaunch a similarly long wrangle over the funding and size of a new hospital to replace the ageing **Whipps Cross Hospital**, now subsumed into the morass of the **Barts Health Trust**. As with Epsom & St Helier the discussion has not yet even clarified where on the extensive Whipps Cross site the new building should be located.

After so many NHS capital assets have been sold off and the proceeds swallowed up covering trust deficits there will be some local concern at a "masterplan" suggesting a "new, taller, building on about one-fifth of the site" and alarm at the prospect of selling off the remainder of the estate "for much-needed new homes and community facilities."

In **Leeds**, too, where the **Teaching Hospitals Trust** has been given the green light to proceed with building new hospitals for adults and children on the Leeds general Infirmary site, the Trust board is far from ready to begin work at once: "The Trust has a number of stages to complete before it can start building the new hospitals, but expects the build to take around three years once it is underway." And as with Whipps Cross the project brings the prospect of land and buildings being sold off "to support the development of a new Innovation District for Leeds". Some, like the Grade I listed Gilbert Scott Building "will be offered for sympathetic redevelopment to preserve their fantastic heritage for the city."

In **Watford West Hertfordshire Hospital Trust** bosses have been "thrilled" by the funding to build a replacement. But there is also an unresolved argument over the location of an acute hospital to serve the catchment area of almost 500,000 people, with non-Watford residents arguing strongly for a new build on a site that is not caught up in Watford's congestion and proximity to the Premier League football ground.

Watford was selected as the main emergency hospital because at that time it was a very important 3-way marginal constituency: but it is the most inaccessible. It can take an hour or more by car from St Albans or Hemel Hempstead at 8am. By bus it is far worse – taking one and a half hours most times.



Whipps Cross "master-plan" is for a "new, taller, building on about one-fifth of the site"

The problem will now have to be aired again with the development of a Business Case: the Trust has promised to share their proposals "as soon as possible": the arguments will resume over how best to invest for future access to health care.

In **Harlow**, the announcement that the **Princess Alexandra Hospital Trust** is free to build the long-awaited and interminably-discussed new hospital has also left management "thrilled" but brought warnings that there will be some delay before anything actually happens. Chief Executive Lance McCarthy said: "We can now put into action our plans to speak with local people about their thoughts and suggestions on the new hospital to make sure that it meets their needs into the future."

Princess Alexandra is a small hospital built in the 1960s for a much smaller caseload and which ended winter 2017/18 with bed occupancy above 99%: just 67% of A&E attenders treated or discharged within the target 4 hours.

Continued next page

List of hospital building projects given go-ahead or "seed funding"

Trust	Hospital(s)	Total backlog maintenance (£m) (2017-18)	DHSC loans to Trust (£m)	Control total/ planned deficit (£m)
Barts Health	Whipps Cross Hospital	78	149	**65.3**
Epsom & St Helier	Epsom, St Helier & Sutton Hospitals	108	n/a	**6.7**
Leeds Teaching Hospitals	Leeds General Infirmary	58	89	**5.2**
Princess Alexandra	Princess Alexandra Hospital	29	66	**28.4**
University Hospitals Leicester	Leicester General, Leicester Royal, Glenfield	77	209	**48.7**
West Hertfordshire Hospitals	Watford General	27	195	**22.7**
	Wave 1 combined loans propping up trust finances		**708**	
	Wave 1 Total of backlog maintenance unresolved	**377**		
	Wave 1 combined planned deficits 2019-20			**177**
21 Wave 2 trusts sharing £100m "seed funding"				
Cambridge University Hospitals	Addenbrookes Hospital	101	403	**33.1**
Dorset Healthcare	Up to 12 community hospitals	0.7	n/a	**-2**
East Sussex Healthcare	Conquest & Eastbourne District Hospitals	35	203	**30.4**
Hampshire Hospitals	Royal Hampshire, Basingstoke & N. Hants Hospital	67	19	**-12.2**
Hillingdon Hospitals	The Hillingdon Hospital	109	76	**24**
Imperial College Healthcare	Charing Cross, St Mary's and Hammersmith	660	34	**16**
James Paget University Hospitals	James Paget Hospital	22	13.8	**5.5**
Kettering General	Kettering General	42	149	**0**
Lancashire Teaching Hospitals	Royal Preston Hospital	27	166.5	**37**
Milton Keynes NHS FT	Milton Keynes Hospital	8	127	**0.4**
North Devon Healthcare	North Devon District Hospital	9	18	**0**
Nottingham University Hospitals	Queens Medical Centre, Nottingham City Hospital	136	120	**27**
Pennine Acute Hospitals	North Manchester General Hospital	3	155	**24.5**
Plymouth Hospitals	Derriford Hospital	0.5	109	**0**
Royal Berkshire NHS FT	Royal Berkshire Hospital	50	17.2	**-1.5**
Royal Cornwall NHS FT	Royal Cornwall Hospital	41	63	**0**
Royal United Bath NHS FT	Royal United Bath Hospital	46	17	**-7.8**
Taunton and Somerset NHS FT	Musgrove Park Hospital	22	22	**6**
Torbay and South Devon NHS FT	Torbay District Hospital	30	90	**-1.7**
University Hospitals Morecambe Bay	Royal Lancaster Infirmary, Furness General Hospital	38	233.8	**60.1**
West Suffolk NHS FT	West Suffolk Hospital	26	96	**0**
	Wave 2 combined loans propping up trust finances		**2132.1**	
	Wave 2 Total of backlog maintenance unresolved	**1,473**		
	Wave 2 combined planned deficits 2019-20			**238.8**

There has been a debate over whether to patch up the existing building or replace it with a new £450m hospital on a "new" site, which may or may not be close to PAH. A Commons adjournment debate in June 2018 brought the statement from Health Minister Stephen Barclay that the STP bid for £500-£600 million to develop a new hospital and health campus on a greenfield site to replace the old hospital had been whittled down to £330m and referred back to NHS Improvement.

Local Tory MP Robert Halfon pressed the urgency of investment: "A 2013 survey rated 56% of the hospital's estate as unacceptable or below for its quality and physical condition. That was five years ago now and the situation is only deteriorating. With long-term under-investment, we are continuing to put the capability of the hospital to care for those in need at serious risk—just read the reports of raw sewage and rainwater flowing into the operating theatres."

However it's clear there will be a considerable delay between the new allocation of funds and the first bricks being laid in Harlow.

Likewise in **Leicester,** where the decision to give the go-ahead to the hospitals Trust to implement its reconfiguration of services is a sharp reminder of the unresolved debates over how services should be organised. Leicestershire and Rutland have just one acute hospitals trust, **University Hospitals of Leicester (UHL)**, operating on three sites: for many years there have been plans to reduce this to two, with the loss of acute beds and services at Leicester General Hospital.

Now Chief Executive John Adler, professing himself "ecstatic" at the news that £450m is now available, has underlined this two-site strategy, arguing that the money would be enough for:

- A new Maternity Hospital and dedicated Children's Hospital at the Royal Infirmary
- Two 'super' intensive care units with 100 beds in total, almost double the current number
- A major planned care Treatment Centre at the Glenfield Hospital
- Modernised wards, operating theatres and imaging facilities, and
- Additional car parking

A pre-consultation business case, reputed to be a staggering 1800 pages long has been kept carefully under wraps, apparently for fear local campaigners would begin to discredit its arguments before the carefully-spun official version could be established with local news media.

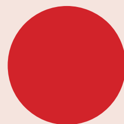
So the announcement that funding is in place for the reconfiguration heralds a fresh round of argument at local level. Campaigners will once insist that concentrating all the Trust's emergency and most inpatient services on the already congested Leicester Royal Infirmary site makes little sense.

Before any new building can commence the Trust needs to brace itself for a full public consultation and construct a viable Business Case – which could also be open to challenge.

Impact on backlog

In total it seems that the six "new hospital" projects could eliminate up to £377m of the £6 billion backlog maintenance bill in England.

However the six trusts are already deep in the red, with combined loans to prop up their finances totalling over £700m, and planned deficits this year of £177m, so the terms on which the money is to be made available for the projects could make all the difference to their affordability.



In Leicester a pre-consultation business case, reputed to be a staggering 1800 pages long has been kept carefully under wraps, apparently for fear of local campaigners

Leicestershire's fantasy road to reconfiguration

The remaining 21 trusts that will receive less than £5m each in "seed funding" to begin to work up plans to begin in the mid 2020s are unlikely to see any major new building until at least 2027 – and some will have to find ways to manage some very significant backlog maintenance bills.

The biggest by far, and biggest backlog in the NHS is **Imperial Healthcare** which needs £660m to tackle **St Mary's Hospital** and its other sites, but will receive nothing for at least six years. Three other hospital trusts (**Cambridge University, Hillingdon** and **Nottingham University**) face backlog maintenance in excess of £100m.

Borrowing

While several of the 21 trusts whose needs have been put on the back burner are actually projecting a break-even or surpluses on revenue spending this year, many are relying on rolling over and increasing loans from the Department of Health that have helped pretty up their balance sheets: these total more than £2.1 billion.

However at least these trusts have the distant hope of some relief: many other trusts across the country face onerous backlog maintenance bills but do not appear on any of the lists of trusts singled out for extra cash. They have no prospect of being able to upgrade or replace their decrepit buildings.

Behind Johnson's bravado, and the obedient gratitude of trusts handed back part of the money they should have had over the past nine years, is a stubborn and growing problem of backlog maintenance, and continued neglect of investment in mental health, community and primary care services.

There is also a prospect of growing frustration in many areas where people may have taken the announcements as good coin, and may respond angrily when they see no change in their local hospitals.

Worse, if Johnson succeeds in pushing through a no-deal Brexit and the warnings of the Institute of Fiscal Studies prove accurate, there would be serious doubts over the promises of future funding six years down the line. Even with "substantial" government spending, the IFS expects the UK economy to flatline for two years, and forecasts government borrowing rising to £100bn.

The IFS warns that any rise in public spending in 2020 would likely be followed by "another bust" as the government would have to deal with "the consequences of a smaller economy and higher debt for funding public services.

IFS boss Paul Johnson summed up:

"An economy that turns out smaller than expected can, in the long run, support less public spending than expected, not more."

Trusts with backlog maintenance of more than £30m, not on any list

Trust	Backlog £m
London NW Hospitals	200
Sheffield Teaching Hospitals	120
St Georges	99
Sandwell & West Birmingham Hospitals	91
East Kent Hospitals	72
Oxford University Hospitals	69
Doncaster & Bassetlaw	67
Medway Maritime Hospital	58
Kingston Hospital	57
Heart of England	48
Royal Free Hospital	47
Mid Cheshire Hospitals	43
Salisbury Hospital	42
Gloucestershire Hospitals	36
Lewisham & Greenwich Hospitals	32
Brighton & Sussex Hospitals	34
Buckinghamshire Healthcare	31
SW London & St George's Mental Health	30
Total	1176

Birmingham's Midland Metropolitan hospital left stranded by collapse of Carillion could be the last PFI hospital completed

HIP, HIP hooray?

New policy 'retires' PFI – but sidelines mental health

John Lister

Since the flurry of main announcements the Department of Health and Social care has published a Health Infrastructure Plan (HIP) as "a new strategic approach to improving our hospitals and infrastructure".

It offers few surprises. The same gaps and skewed priorities that can be seen in the first round of allocations under the Johnson government run through the HIP.

There are no new resources to tackle the rising bill for backlog maintenance, even though the scale of the problem is referred to on page 9:

"There is significant unmet demand for capital in the system. A key example of this is that the NHS is reporting significantly increasing levels of backlog maintenance, up 37% between 2014-15 and 2017-18 to £6.0bn, with the highest risk category ('significant') rising most rapidly."

Backlog: trusts left to cope

But by page 11 this had shifted to a general aspiration for an NHS that "proactively takes steps to maintain assets and reduce backlog maintenance," and by page 17 the problem has been deftly shuffled back onto the trusts themselves to pull themselves up by their own bootstraps:

"… Taking responsibility for the on-going 'business as usual' maintenance of their healthcare estates, ensuring they are sufficiently surveyed, and sensible investment decisions are made and prioritised accordingly."

Similarly the HIP offers no hope for trust boards, management and staff trying to deliver mental health services in decrepit and unsuitable buildings. It begins with brave words on page 6:

"The HIP is not just about capital to build new hospitals – it is also about capital to modernise mental health facilities, improve primary care and build up our infrastructure in interconnected areas such as public health and social care …"

The same platitudes are repeated on page 14, but the document contains no commitments to any significant investment to make this possible, and it's clear that the promises, if any, will only come in the future:

"The full shape of the investment programme will be confirmed when the Department for Health and Social Care receives a multiyear capital settlement at the next capital review and will feed into the phases of HIP – and at that point an updated version of this document will be published."

So these priorities for the NHS are ignored and 93% of the £3.7 billion of new money is focused on the acute hospital sector.

Nail in coffin of PFI

However there are some new aspects to be noted in the HIP, most notably banging the final nail into the coffin of the Private Finance Initiative, a failed Tory policy which the Johnson government is now keen to link to the Blair government, which implemented it with most vigour in the NHS.

The HIP (page 9) has a clear commitment to public funding of any new hospital development:

"The retirement of off-balance sheet government-funded infrastructure (formerly known as "PFI" or PF2) has also removed a significant source of funding from the system, given the majority of new acute provision over the past 20 years has come through PFI. **It is therefore clear that public capital funding will be needed to deliver new large hospital replacements in the future.**"

Former NHS finance director and analyst Roger Steer, speaking to ***The Lowdown***, pointed out the limitations of the HIP as a strategy:

"While some chosen projects have received good news the reverse of the coin is that the announcements represent years of delay for other projects, equally as urgent and pressing. Projects should be receiving capital and revenue support based on need and the quality of the business case; and shouldn't be required to wait in a queue for years.

"£2.9bn only represents a proportion of backlog of projects built up over the years and the total bids for capital in the STP plans of 2016 added up to more than £20bn.

"The other word of caution is that the Treasury is not mentioned once. It is clear that this is a hasty announcement that may not have the Treasury's full backing.

"If the economy nosedives after Brexit we may be back to stop in the stop –go cycle, with capital spending as the first item on the list of cash savings."

"The majority of new acute provision over the past 20 years has come through PFI. It is clear that public capital funding will be needed to deliver new large hospital replace-ments in the future"

In our first year we pledged to:

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

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

THE lowdown

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

Informing, alerting and empowering NHS staff and campaigners

RCP warns of vacancies

THE rate of unfilled NHS consultant psychiatrist posts has doubled in the last six years in England, according to a survey by the Royal College of Psychiatrists.

One in 10 posts are vacant, up from one in 20 in 2013.

Vacancy rates are particularly high in areas of mental health care prioritised by the Government for improvement, prompting fears that plans to transform services over the next 10 years under a major investment programme will fail.

They are also higher in some regions: in eating disorders, the vacancy rate for consultant psychiatric posts is 11% in the East Midlands (Trent), but soars to 17% in the South East and South West and 33% in the East of England.

Although access to children's mental health services in England is improving, only 35% of those who need it get treatment.

Earlier this year, a report published by the College found that people with eating disorders can wait up to 41 months for treatment, with adults waiting on average 30% longer than under-18s.

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

Private GP service sets sights on further NHS expansion

Paul Evans

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

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

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

Problems for CCG

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

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

However, changes announced in late September by NHS England and NHS Improvement will change this and have a significant effect on the way Babylon Health operates from April 2020 onwards when they come into force.

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

Financial burden

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

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

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

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

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

The app will see you now …

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

IN THIS ISSUE

- **WHO WE ARE** – and why we need YOUR help to sustain The Lowdown - Back
- **FAKE FORTY** 4 pages of background & analysis on promised new hospitals 7-10
- **BLUE on BLUE** Shropshire's Tory MPs row over Telford hospital downgrade 10-11
- **PFI R.I.P.?** A closer look at the new Health Infrastructure Plan 11

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Without your support this will not be possible.

Help us keep The Lowdown running in 2020

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

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

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

We know from our surveys that many readers are willing to make a contribution, but have not yet done so. We are now asking those who can to give as much as you can afford. We would suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can give us more, please do.

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

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

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