THE lowdown

Health news, analysis and campaigns.
NUMBER 16, January 17 2020

Informing, alerting and empowering NHS staff and campaigners

Dash in to take charge in NW London

You couldn't make it up. Nine months ago North West London's NHS bosses were told by Matt Hancock that their long-running, ruinously expensive and impractical plan for reconfiguration ("Shaping a Healthier Future") was being scrapped.

The project had squandered almost £80m on management consultancy over the previous ten years, but never even completed a business case. One of the contractors was McKinsey.

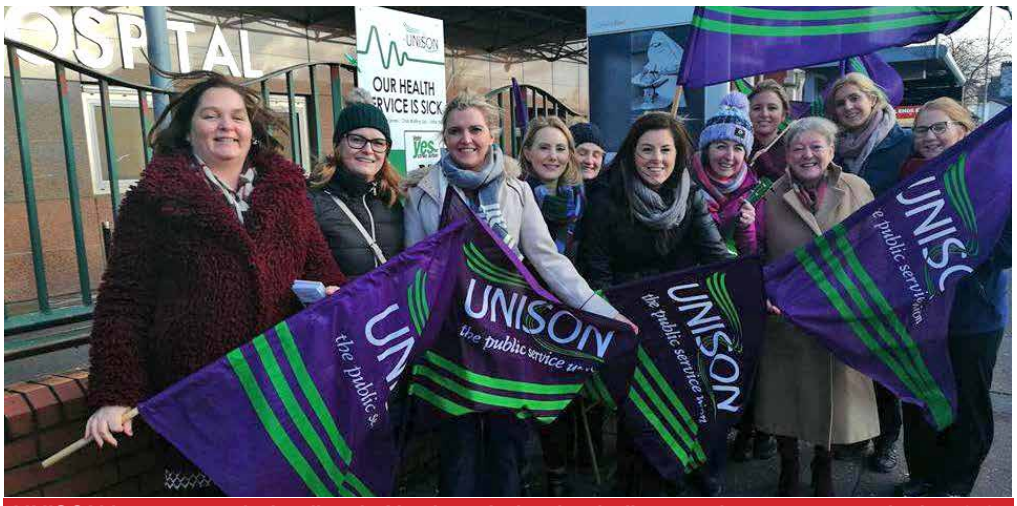
Now NHS England/ Improvement have announced NW London's "integrated care system" should be chaired by a senior partner of McKinsey – Penny Dash.

McKinsey's website notes that she is "a leader for our work with healthcare payors in Europe, the Middle East and Africa": another McKinsey biog extends her reach to Australia. She was previously the head of strategy for the National Health Service (NHS) in the United Kingdom, and was the vice chair of The King's Fund from 2006 to 2015.

It seems that after lamentably failing to deliver a workable plan, McKinsey now gets another go.

The results so far are poor: December A&E figures include only 2 of the 4 trusts covering NW London: London NW Hospitals could only see **60.8%** of the most serious Type 1 A&R cases within 4 hours, while Hillingdon did even worse, at **56.3%**.

If this is the outcome of ten years of McKinsey's efforts, how much more "improvement" can local services survive?



UNISON has suspended strikes in Northern Ireland to ballot members on a new deal - p8-9

New buildings can mean fewer beds

The Johnson government has swept to power on the back of extensive promises to invest in and improve the NHS – but many of these promises will soon be under the spotlight.

The latest performance figures show the NHS is struggling to cope with winter demand for emergency admissions and to maintain elective services with 95% of beds occupied even after opening 4,500 "escalation beds".

But more and more people in various areas are realising that the promise of extra money for new buildings or even a new hospital does not necessarily mean more beds: it could mean fewer.

In **Poole, Dorset**, Matt Hancock has just rubber-stamped the downgrade of their local hospital, to centralise emergency care in Bournemouth, which has not met A&E targets for almost five years.

The NHS has 95% of beds occupied is struggling to cope with demand even after opening 4,500 "escalation beds".

The reconfiguration project has been allocated £147m to cover a new emergency department and critical care unit in Bournemouth – but no significant extra beds: so will the new set-up cope with demand?

In **South West London**, it has been announced that a new specialist emergency care hospital to replace Epsom and St Helier hospitals will be in Sutton: but it's also clear that the £500m project will have only 400 beds – whereas the current Epsom & St Helier Trust has 747 general and acute beds. Both of the existing hospitals would be downgraded to urgent care only: how would services cope with this reduction?

In **Shropshire**, too, a controversial £312m project signed off by Matt Hancock only months ago to rebuild Shrewsbury Hospital and "centralise" emergency services, downgrading Telford,has soared in cost to £498m, but includes no extra beds. With Shropshire's A&E already registering the worst 12-hour trolley-waits in England, and A&E demand **up 27% in a year,** how can they cope if they downgrade Telford?

Extra money does not ensure sound policies: expect more risks to be taken as ministers show their real intentions for the NHS.

IN THIS FIRST ISSUE OF 2020

Social care adds to winter pressure: what's being done?

Molly Dawson and Paul Evans

Another winter, another set of broken records for the NHS. A&E waiting times for December hit their worst level on record, with 2,000 patients waiting 12 hours for a bed. Experts cite the struggle to find social care support as one of the key causes of increased pressure.

Demand for social care is rising, but cuts in services mean that fewer people receive care.

Tens of thousands of older and disabled people are being denied basic support such as help with washing and dressing and overall Age UK estimates suggest there are 1.4 million elderly people not receiving the care they need.

The impact is familiar: neglected health conditions worsen, eventually piling on the pressure to A&E and an inpatient hospital beds.

The lack of social care packages also means many patients are stuck in hospital waiting for support to allow them to go home.

After a period of funding cuts, the government is putting some more money into social care, but like the health service, social care is also facing a workforce crisis.

Staffing shortages in the social care sector stand at 122,000. To meet the needs of the ageing population, there is a projected need of 580,000 additional social care workers by 2035.

Boris Johnson pledged to fix the social care crisis in his first speech as Prime Minister.

The Conservative manifesto said it would put £5billion towards social care over the next five years – but so far no plan has emerged.

How is social care funded currently?

The funding of social care is complex and confusing, with many people unaware of the potential costs involved until they reach a point of needing the services, but in reality it rarely ends up being free.

Even if you have care needs resulting from healthcare conditions like dementia or Parkinsons disease, you will only receive NHS funding for significant and ongoing problems.

People with dementia typically spend £100,000 on the care they need, according to the Alzheimer's Society.

Otherwise you will be directed towards your local council who are responsible for organising social care services. People with assets over £23,350 must pay for their own social care.

Even for those who get help, cuts to council funding since 2010/11, have meant that less care is available. Indeed despite recent funding increases, spending is still around £1 billion less than it was at the start of the decade.

As a result, the number of elderly people receiving publicly funded care fell by 400,000 between 2009 and 2016.

The Health Foundation estimates that an additional £12.8 billion of funding would be needed to bring back social care to the access levels of 2010/11

What has been suggested to solve the social care crisis?

Various commissions and reports have been dedicated to solving the deep-rooted issues in social care over the last 20 years. Governments of all colours have kicked the issue into the long grass, fearful of confronting voters with extra taxes or insurance payments.

The Royal Commission on Long-Term Care in 1999 called for care costs to be split between living costs, housing costs and personal care. They suggested that personal care – help with washing, feeding and medication be free at the point of use.

This was rejected by the then New Labour government, but was adopted in Scotland.

The Dilnot Commission in 2011 set out plans to protect people from extreme care costs, which the King's Fund described as a 'costed and credible' way forward. It recommended a cap on care costs after which the state would pick up the bill.

The Barker Commission in 2014 went further by calling to establish more equitable support by removing the barrier between health and social care, introducing a single ring-fenced budget and raising the amount of free social care.

Election debate

In the midst of many promises at the latest election, the Labour Party proposed plans for a 'national care service' with free personal care for over-65s.

However, the pledge had little detail to it, and the £11.1 billion funding pledge still falls short.

In fact, a Health Foundation analysis found that none of the main party's election promises pledged enough to meet growing demands. It estimates that an additional £12.8 billion of funding would be needed to bring back social care to the access levels of 2010/11.

Amongst the plans from charities and campaigners is a report by the National Pensioner's Convention - Sustainable Funding for Social Care, which describes in more detail how a National Care Service might work.

Their plan is costed at £12 billion and would provide free domiciliary and residential care to service users who are currently self-funding. It would also expand to cover:

- 1.2 million older people whose needs are currently excluded from the system,
- modernisation of residential homes,
- improved terms and conditions for care staff,

- and improved monitoring and regulation.

There are various options available for funding this cost outlined in the report. These include:

- restricting pension tax relief to 20% for all earners, raising an annual £12 billion
- reversing previously proposed corporation tax cuts from 20% to 17% could save £7.5 billion.

What is the Government doing now?

In November 2019, PM Boris Johnson announced to business leaders that he would be shelving the planned reduction of corporation tax. Instead he pledged to spend the savings on public services.

However, the Tory election manifesto failed to outline any solid plans on social care. It pledged a vague plan to "build a cross-party consensus on long-term social care funding" and only an additional £1.1 billion in funding, well short of the £12.8 billion figure outlined by the Health Foundation.

Calls for a cross-party consensus, which has not been unachievable in the past, seem less necessary for a Government that has a big enough Parliamentary majority to push through its own agenda.

So where is the big idea?

The last detailed Tory policy pledge on social care was announced by Theresa May during the 2017 election.

The idea was that people would pay for care until their assets had fallen to value of a £100,000, including their house: but payments after death could eat into any inheritance.

It was dubbed a 'dementia tax' in the press and subsequently dropped.

Ever since there has been a palpable reluctance by government to move forward on the issue.

Publication of a Green Paper on Social Care was repeatedly postponed, and is now three years overdue, originally planned for the summer of 2017, but delayed by an election, Brexit negotiations and more elections.

Despite the delays, social care still sits at the top of the PM's in-tray and his own stated priority list – so surely it can't be avoided.

Or can it?

How seriously is the government commited to the Long Term Plan?

John Lister

On January 15 the Johnson government tabled the NHS Long Term Plan Funding Bill which they argue will "protect in law" an extra £33bn every year by 2024 for the NHS to transform care. Labour unsuccessfully attempted to move an amendment to increase the amount of money. The sum on offer is clearly not enough.

The official press release states that "The bill will contain a 'double-lock' commitment that places legal duty on both the Secretary of State and the Treasury to uphold this minimum level of NHS revenue funding over the next 4 years."

However there are concerns among sharper-witted observers, such as the Nuffield Trust's Sally Gainsbury, that the amount of money being guaranteed is stated in *cash terms* only, and can therefore be vulnerable to inflation.

Indeed, as we have pointed out in the Lowdown, when it was first announced the £33.9bn figure was stated by Theresa May's government to be equivalent to just **£20.5bn** in 'real terms' by 2024.

It seems that the legal "lock" is also a means of preventing any higher sum being allocated – in other words the **"minimum level"** is also the **maximum** – so unless there is new legislation NHS services will continue to decline for lack of resources over the next five years.

New legislation

There also appear to be some doubts over the extent to which the new government will carry through the legislation called for by NHS England to create a legal framework for their so-called "integrated care systems" in the Long Term Plan.

Early last year NHS England attempted to enlist public support for proposals to scrap compulsory competitive tendering, the "Section 75" measures and regulations.

Even while they promoted these changes, NHS England continued to drive through a range of tenders and outsourcing of services including hi-tech scanning services, making it clear that their plan was still completely consistent with further fragmentation and privatisation of selected services.

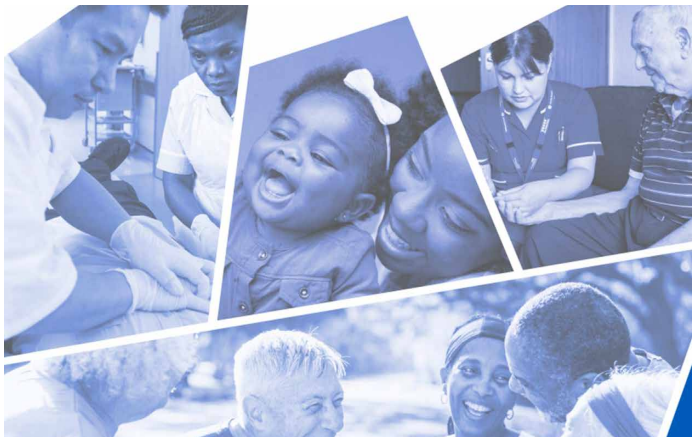
It has been clear from the outset that to get rid of some of the unwanted baggage of the 2012 Health and Social Care Act and pave the way for various so-called "integrated" bodies would require legislation, which Theresa May's ministers and subsequently Johnson have until now appeared to accept.

However despite the high hopes of NHS England bosses and the apparently categorical promise in the Conservative Party Manifesto that "Within the first three months of our new term, we will enshrine in law our fully-funded, long-term NHS plan," the explanatory notes to the Queen's Speech are much less clear cut.

Evasive

Under the heading "DELIVERING THE NHS LONG TERM PLAN" the wording is vague and evasive, stressing the need for "thorough consideration":

- **In September 2019 the NHS published a set of recommendations for legislative changes that would enable the NHS to go faster and further in realising the ambitions set out in the 10-year NHS Long Term Plan.**
- **The Government welcomes the NHS's leadership of this work, and all the input from people across the health and care system and is committed to supporting the implementation of the NHS Long Term Plan.**



- **The Government is considering the NHS's recommendations thoroughly and will bring forward detailed proposals shortly. This will include measures to tackle barriers the NHS has told Government it faces.**
- **This will lead to draft legislation that will accelerate the Long Term Plan for the NHS, transforming patient care and future-proofing our NHS."**

Whether this legislation, when it eventually takes shape, will go as far or as fast as NHS England is hoping remains to be seen.

The knighthood in the New Year Honours for NHS England boss Simon Stevens, despite five years of constantly declining performance of the NHS, might suggest ministers are favourably disposed to his proposals.

Or it might be a sign that the ***HSJ*** was right last summer to suggest Stevens may be planning to step down in the second half of this year, and this is paving the way for his departure before another set of his plans begins to unravel.

High number of assaults still take place on mixed-sex mental health wards

The Health Service Journal (HSJ) has obtained figures on the number of sexual assaults reported each year on mixed-sex mental health wards in England.

The publication notes that the hundreds of assaults make it clear that investment is badly needed to protect patients and improve facilities.

HSJ figures, obtained via freedom of information (FOI) requests, showed there there was at least 1,019 reports of sexual assaults between men and women on mixed wards from April 2017 to October 2019.

In comparison, over the same time period there were just 286 reports of incidents on single-sex mental health wards.

In December 2018, Sir Simon Wessely's review of the Mental Health Act recommended changes to the definition of single-sex accommodation to ensure wards are "genuinely" single sex.

The current rules were considered to be too weak.

The 2018 review noted that the definition of 'single sex accommodation' needs to make sure that sleeping accommodation, bathrooms and daytime spaces are genuinely single sex, with optional mixed sex daytime space available.

HSJ reported that data from the FOI requests found there are hundreds of mixed-gender wards and communal areas still in use.

Of the trusts which responded, there was a total of 668 mixed-sex wards and 803 mixed-sex communal areas.

The Department of Health and Social Care has not yet changed its definition of single-sex accommodation in line with the December 2018 review, and did not respond to ***HSJ*** when asked if it would change its definition.

Charity mental health provider misled CQC

The Care Quality Commission has published a critical report on the independent mental health provider, St Andrew's Healthcare. The charity, which mainly operates in the Midlands, was rated "requires improvement".

The report contained a number of concerns, including that in previous inspections records had been falsified for the CQC thus covering up allegations of poor care and abusive behaviour.

The CQC's report states: "Patients, staff and relatives raised concerns that management may either not be aware of or are not responding to issues including poor and selective reporting, falsifying records, intimidation of staff, and active deception of [the] CQC."

The CQC also stated that "staff did not consistently feel confident to raise concerns without fear of reprisals. The provider had not afforded the appropriate protection to one staff member under The Protected Disclosures Act 2014."

In November 2019, St Andrew's was found to have unfairly dismissed a nurse after the charity discovered that they had been involved in previous whistleblowing cases at other providers and had reported concerns soon after he was employed by St Andrews. He raised concerns with trainers during his week-long induction about fellow inductees cheating on e-learning modules by screenshotting the answers.

The CQC inspectors were also shown evidence that staff who had been dismissed following abusive or threatening incidents with patients had been re-employed by St Andrews.

St Andrew's Healthcare is one of the largest charities involved in residential mental health services. Its hospitals have received a number of critical reports in recent years.

In June 2019, its Northampton hospital was rated "inadequate" by the CQC.

The watchdog had found that adolescents were kept in unsafe seclusion rooms for excessive amounts of time and without beds, blankets or pillows.

It was reported that some patients had been in seclusion for years. Earlier in 2019 the Victoria Derbyshire programme was given footage of a teenager reaching their arm through a door hatch to enable contact with their parents during a visit to the hospital.

The CQC gave St Andrew's six months to improve this service, and if it does not do so the hospital's registration will be cancelled, effectively closing the 99-bed site.

Thousands of young people rejected by mental health services

Sylvia Davidson

Tighter restrictions on access to mental health services means that thousands of young patients are being denied care, leading to a large rise in the numbers turning up in A&E; pressures that are described in a string of new crisis reports.

Over a quarter (26%) of referrals to specialist children's mental health services were rejected in 2018-2019 according to a new report by the Education Policy Institute.

Despite referrals by GPs judging that special care was needed, an estimated 133,000 children were denied care by mental health providers last year for not being suitable for treatment, or because their conditions did not meet the eligibility criteria.

The tightening of the criteria was confirmed by A ***Pulse*** survey of 935 GPs in which nearly 30% said the rules governing referrals to adolescent mental health services

(CAMHS) had become stricter in the past year.

Freedom of information replies from 29 NHS mental health trusts in England (out of 56) revealed that a third restrict care to patients with 'severe/ significant' conditions, for specialist child and adolescent mental health services (CAMHS).

According to the analysis by ***Pulse*** only one in five NHS mental health trusts accept referrals for children with mild, moderate and severe mental health conditions.

Children in areas with restricted access have to wait until their condition worsens before they qualify for treatment. in some cases this has led to children attempting suicide before their referral is accepted.

This was the case for 16-year-old Sam Grant, who was referred to CAMHS by his GP, but his referral was rejected because his symptoms did not meet the threshold of 'moderate to severe'. Sam died by suicide in October 2019.

An inquest noted the issue of the threshold criteria at Sam's local CAMHS, but also that the service had also not suggested alternative assistance.

Charities can't cope

GPs are being told to refer the young people rejected by CAMHS to services provided by charities, however they are also often struggling with the increase in demand and they rarely have psychiatrists, but are based on counselling and can not provide specialist help.

A survey by the charity YoungMinds published in early November 2019 found that over three-quarters (77%) of 1,008 GPs felt community support for child mental health problems was not good enough, and almost the same number did not feel confident that their referrals to CAMHS would result in treatment.

A&E is last resort

It is also now clear that A&E is increasingly been seen as the only option for young people in crisis, these could be those rejected by CAMHS or those on the long waiting lists for an appointment.

An analysis by The Independent of data from 2010 to 2019 found that there has been a 330% increase in children and adolescents turning up in A&E with mental health conditions.

It is true that demand for CAMHS has risen significantly, with referrals were up by 18% between 2017/18 and 2018/19 alone, according to NHS Digital data.

However, this is not a sudden rise: demand has been rising for a number of years, but capacity has not increased.

Andy Bell, deputy chief executive at the Centre for Mental Health policy think tank, told The Independent that the data on A&E visits was not a surprise:

"There has been a significant increase in demand but we haven't seen an increase in capacity.

"That will be one reason for this in that people are being made to wait longer for help and more children are reaching crisis point."

In a survey 43% of UK family doctors said they told parents whose children were struggling with anxiety, depression, self-harm or eating disorders to seek treatment privately.

Advised to 'go private'

One effect of the high number of referral rejections and the delays to getting help is the number of GPs now advising parents to seek private care for their children. In a survey by the mental health charity Stem4, 43% of UK family doctors said they told parents whose children were struggling with anxiety, depression, self-harm or eating disorders to seek treatment privately.

Many of the GPs that took part in the survey for Stem4, were highly critical of CAMHS, describing services as "dire", "extremely lacking", "non-existent" and "totally, horrifically, grossly inadequate".

In this 2019 survey 90% of GPs described CAMHS in their area as 'extremely' or 'very' inadequate, in 2016 this figure was 77%.

Driving those patients that can afford it towards private care signals the path to a two tier system, with children from poorer families being denied care or having to wait longer, potentially with worse and sometimes tragic outcomes.

Dr Nihara Krause, a consultant clinical psychologist and founder of Stem4: noted that

"Parents whose child has cancer or a serious physical health condition would never have to pay for private care, so why should it be OK for those whose children have mental health problems to be told to do that?

"This again shows that the much-vaunted 'parity of esteem' between physical and mental health services is still a far-off goal."

Providers and Royal Colleges speak out as NHS performance falls to its worst-ever level

John Lister

NHS Providers, professional bodies and Royal Colleges have been increasingly forthright in their warnings on the state of the NHS in the run-up to the election and the period immediately afterwards.

It's clear they are reflecting the growing frustration of their members and of health staff generally caught at the sharp end of a system that is being pushed to the very limits of endurance as demand pressures continue to rise, funding, staff and resources lag ever further behind, and ministers roll out inane and deceptive statements to mislead the public on the scale of the problem.

NHS Providers, which represents NHS trusts, trod a diplomatic line of welcoming statements by Boris Johnson and the Conservatives committing to improve the NHS, while also pointing to the growing gap between the amounts needed and the limited resources available. They urged ministers to get "Back to reality" in a statement following the Queen's Speech.

Its deputy chief executive Saffron Cordery argued that

"We've had a stark reminder over six weeks that in many ways it's a time of fantasy politics, with policies and promises designed to cut through to voters rather than necessarily address reality."

The reality is stark indeed:

"Performance in the hospital sector and across the urgent and emergency care pathway reached the lowest point in the 10 years since we have been monitoring the constitutional standards. And we know the pressures are just as great in community and mental health services, although not yet measured in the same way.

"In November, only 71.3 % of patients at major A&E departments were seen within four-hour waiting time target – the lowest on record.

"Bed occupancy, at 94.9%, was much higher than recommended levels. The number of ambulance arrivals over the week breached 100,000 for only the second time ever. You get the picture."

Limited funding increase

Another statement from NHS Providers points out that:

"While the commitment in the Queen's speech to deliver a 3.4% annual real-terms increase in NHS funding is very welcome … We need to be realistic about what this funding will buy and what the public should expect.

"This investment will maintain standards at their current level, but the service needs additional real investment to meet the needs of the future and deliver the improvements we all want to see."

Performance in the hospital sector and across the urgent and emergency care pathway reached the lowest point in the 10 years since we have been monitoring the constitut-ional standards

NHS Providers didn't just bang the drum for more money for hospitals: instead the demands were for improvements elsewhere in the system:

- **"a sustainable solution to the current social care crisis …**
- **"a reversal of the cuts to public health spending," with investment in prevention services, and**
- **"a move away from the hospital-centric focus," to invest in mental health, boost primary care and community services.**

NHS Providers chief executive Chris Hopson has calculated that the real terms virtual freeze on health spending since 2010 has meant that current NHS spending in England is £35 billion less than it would have been if previous average increases had continued.

But BMA chair Dr Chaand Nagpaul has pointed out in a memo to ministers that the gap will increase by another £6.2 billion by 2023 if spending is only increased by the £33.9bn cash /£20.5bn real terms increase Johnson's government has promised to enshrine in law.

The BMA's calculation is based on their view that an annual 4.1% increase in real terms is needed to keep pace with rising demand and cost pressures.

Still waiting for extra GPs

Meanwhile the Royal College of General Practitioners has opened the new year by calling the bluff of ministers who keep promising implausible numbers of extra GPs. Its Chair, Prof Martin Marshall states the service has been "running on empty" for too long, and demands a change:

"The situation in which we find ourselves has not happened overnight, and the College has been sounding the alarm bells for many years.

"Whilst workload in general practice has escalated in terms of volume and complexity, successive governments have failed to invest sufficiently in the family doctor service in order to keep pace with demand, and one consequence is that we now have a worrying shortage of GPs.

"We hope that the new Government will take this seriously and that it will deliver quickly on its General Election manifesto pledge of 6,000 additional GPs and many more thousands of the wider general practice team."

Numbers of GPs have declined by over 1,000, and numbers of GPs per head of population have fallen since Jeremy Hunt infamously promised an extra 5,000 five years ago, and the leading health think tanks warned last year that it was unlikely the shortfall in GP numbers would ever be reversed.

But it's hospital crises that tend to hit news headlines, and promises of new hospitals to be built have been prominent in ministerial claims to be prioritising the NHS, along with inflated claims to have already built 18 new hospitals since 2010.

As the i has pointed out, at least 11 of the 18 projects claimed by Johnson's ministers are not new hospitals, but "redevelopments, refurbishments or changes to existing hospital sites, such as integration or relocation".

At least half of the projects were also initiated by Gordon Brown's New Labour government, including a new Mental Health Unit at University Hospital Birmingham which opened in June 2010, a new build and refurbishment at Hope Hospital Salford in September 2011, and the new build and reconfiguration at University Hospital of North Staffordshire NHS Trust.

Will new hospitals mean extra beds?

Among those responding to this spurious claim was Dr Susan Crossland, president of the Society for Acute Medicine (SAM), who also told the i:

"Whilst investment in the crumbling infrastructure of the NHS property portfolio is of course welcome … we call into question whether this will ease the current pressures we see and we call on the government to be honest and account to the tax paying public.

"Are there going to be any more beds in the system, or are we going to continue to see further reductions which are unsustainable in the current climate?"

The SAM has reinforced calls from the Royal College of Emergency Medicine (RCEM), which has been pressing hard for more beds in the system to ease the overcrowding and crisis conditions that threaten safe treatment in A&E departments.

In January the SAM responded to the publication of the latest performance figures, warning:

"We can honestly say that acute care is facing pressures the like of which we have never seen and the huge jump in patients waiting more than 12 hours should be of serious concern to the government.

"… The target of 95% for the standard was last met in July 2015. There has been too little support, too late and the Society calls on central government to urgently tackle the shortage of beds, the lack of staff and the social care system so that hospital staff can work in a safe and sustainable system, providing world class treatment to those who need it."

Since 2010-11 attendances at Type 1 Emergency Departments in England have increased by 1.7m (12.5%) – equivalent to the workload of 22 medium-sized departments

Both SAM and RCEM are also warning that without extra capacity to deal with rising demand the ambitions of NHS England to widen the availability of "same day emergency care" (SDEC) will come to nothing.

The Long Term Plan a year ago suggested rolling out SDEC across the NHS could prevent up to 500,000 overnight hospital stays over the year.

Functioning impaired

However, an audit by the Society for Acute Medicine (SAM) found almost half (45%) of SDEC units had their "functioning impaired" by hospital trusts utilising the space as overflow for admitted patients.

Many do not provide evening or weekend SDEC services, and a report last October showing just over a third of units (35%) were only open five days a week.

"For all its good intention, the NHS's grand plan to use SDEC to improve care and capacity this winter has been grossly derailed as trusts scrounge for additional beds," said Dr Susan Crossland, president of SAM. Dr Nick Scriven, immediate past president of SAM, added: "We are increasingly concerned we will never see SDEC fully implemented as desired if units are constantly seen as the 'easy' target when under-pressure managers need extra bed spaces."

The RCEM brought a number of these issues together in its General Election Manifesto, which argued "eliminating crowding in our Emergency departments must be the number one priority."

…

"Since 2010-11 attendances to Type 1 Emergency Departments in England have increased by 1,748,283 (12.5%) – equivalent to the workload of 22 medium-sized departments. Every year, millions of people turn to our Emergency Departments as increasing numbers are living longer with a complex range of medical needs. Primary and social care services have not been developed to address this need."

Recommendations

The RCEM's recommendations to address the problems in A&E are bold – going much further than Johnson and his ministers have been willing to promise:

"1. Increase the bed capacity in hospitals to maintain flow in Emergency Departments. We estimate that at least 4,000 extra staffed beds are needed in England alone this winter to achieve 85% bed occupancy.

"2. Immediately publish a Social Care White Paper, with the view of expanding social care provision to improve patient flow and address delays in transfers of care in Acute Hospitals. Additional funding must address the £2.3 billion shortfall in social care faced by councils, as advocated by the Local Government Association."

They want ministers to "Ensure sufficient capital funding is available for trusts to transform the emergency care system at pace to ensure it is fit for purpose."

Mental health

Far from narrowly focused on hospital care, the RCEM have also pressed for urgent action to improve GP services, expand social care to support frail elderly people in their homes, and also "Build on the commitments outlined in the Forward View for Mental Health and NHS Long-Term Plan and accelerate the expansion of mental health services."

The RCEM also want urgent action by ministers to deal with the crisis their government has created with its absurd pension taxation policy, driving consultants to cut their hours.

Real anger unites Northern Ireland's health unions striking for fair pay

As we finalise this issue of the Lowdown, UNISON has just announced that it is to suspend its strikes by NHS staff across Northern Ireland, and put a new deal to a ballot. The battle for pay parity with staff doing the same jobs in the rest of the UK was supported by all of the health unions – including the first-ever strikes by members of the Royal College of Nursing.

PATRICK LAWLOR (writing here in a personal capacity), in an article written on January 7 for *Health Campaigns Together* (before the agreement was reached in talks with the unions) is a Neonatal Intensive Care Specialist Nurse Practitioner in Belfast, and Vice-President of Northern Ireland Public Service Alliance (NIPSA), whose members have also been on the picket lines.

The health service across Northern Ireland has been at crisis point for many years as a direct result of chronic and systematic policy of under-funding and pay austerity. This has resulted in £millions of pounds taken out of the health budget of the devolved Regional Assembly of Northern Ireland.

These cuts are part of Westminster Conservative austerity strategy to make working people pay for the financial crisis of 2007/8 caused by the greed of wealthy profiteers and big business.

However these cuts have been implemented without resistance by the local political parties, who fully accepted the neo-liberal agenda of public sector cuts and privatisation.

Pain

The impact of these attacks has caused overwhelming pain and suffering to both patients and staff for over 10 years. As I write, not one clinical target has been met in all main health priorities such as cancer, cardiac and emergency services and many more.

Official figures starkly show 108,582 people were waiting over a year for their first hospital appointment. That is over a third (35%) of the total number of 306,000 patients currently on hospital appointment waiting lists.

This is an all-time high for Northern Ireland, increasing by 8% in the last year.

According to local Health and Social Care Board statistics, the number of people waiting longer than a year for a first outpatient appointment rose by more than 3,000 in just three months between June and September 2019.

Official figures starkly show 108,582 people were waiting over a year for their first hospital appoint-ment. … This is an all-time high for Northern Ireland, increasing by 8% in the last year.

This is at a time when the number of people waiting longer than a year for surgery has risen from 22,638 to 25,279.

This situation has become so serious that thousands of patients across Northern Ireland have been forced to pay privately for treatment.

The overriding objective is to undermine confidence and support for a fully publicly-owned health service and to open it up to the private sector and insurance-based health system.

Tipping point

The current working environment for staff has reached tipping point of unachieveable workloads resulting in work-related physical and mental health conditions impacting many workers.

Many health workers are having to work far beyond their finish times without pay just to keep services going.

The imposition of the cuts agenda on services and pay austerity has seen a recruitment crisis unfolding over the last decade.

There are currently 7,000 vacancies across our health service of a workforce of 60,000, a vacancy rate of over 10% that is getting worse!

This has seen thousands of pounds of public money given away to private sector recruitment agencies to cover vacant posts. Public sector agency spending has surged by 160% since 2015, and estimated to hit £230 million at the end of 2019.

This disgusting and unaccountable waste of money is commonly understood by health workers as money, which could easily go a long way to resolve the recruitment and training crisis in our health service.

Parity of pay

However, it is also recognised that recruitment can only be sustained if the pay cap on wages is broken and staff get parity of pay with their colleagues across the regions of England, Scotland and Wales.

A decade of 1% pay awards has seen a divergence of pay across the National Health Service (NHS) for workers doing the same job.

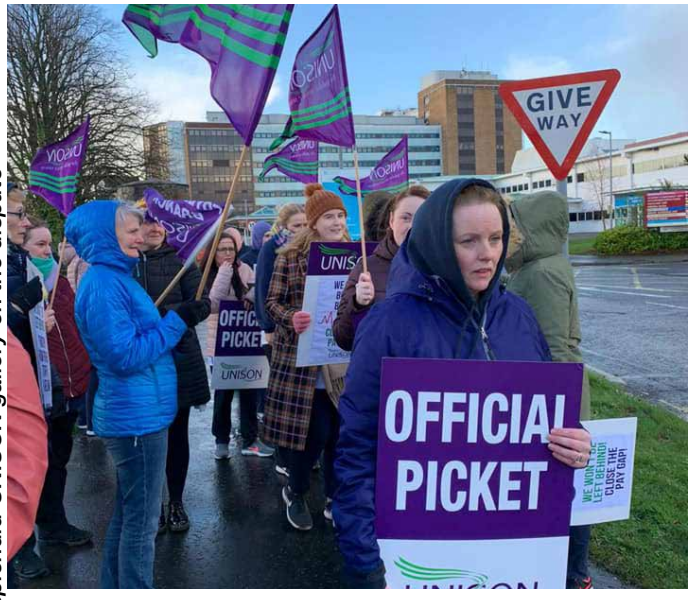
On average a health worker in Northern Ireland is approximately £2000 worse off than their counterpart in other regions. It has been reported that many staff including nurses are regularly having to go to food banks to feed their families as they struggle to pay their utility bills.

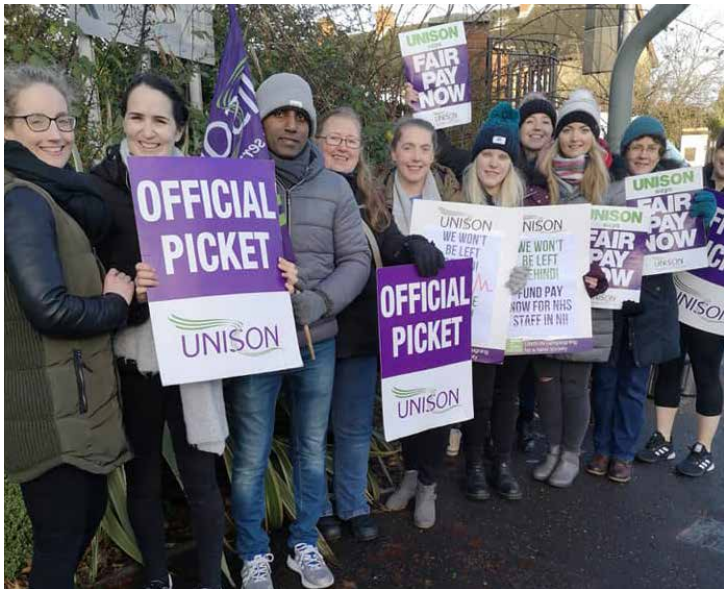
This is the context that saw the explosion of industrial action by health workers spill out across Northern Ireland on the 18th of December 2019, with many of the picket lines having the quality of mass pickets.

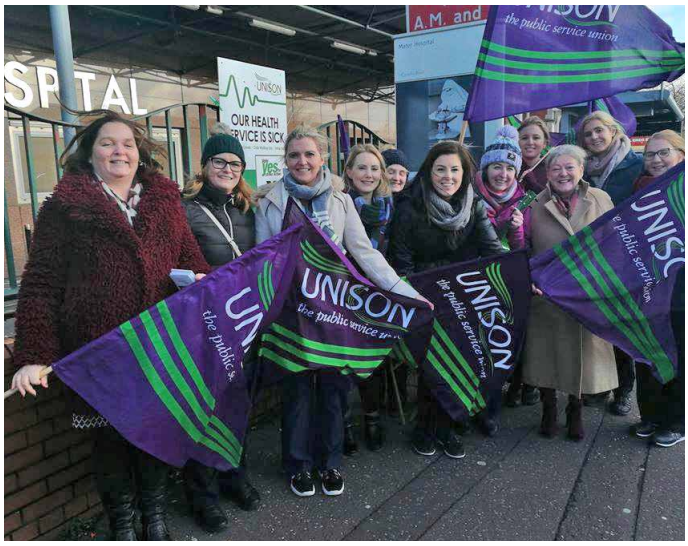
It is not unreasonable to say the action on the 18th resulted in one of the largest health strikes across Northern Ireland since the 1980s.

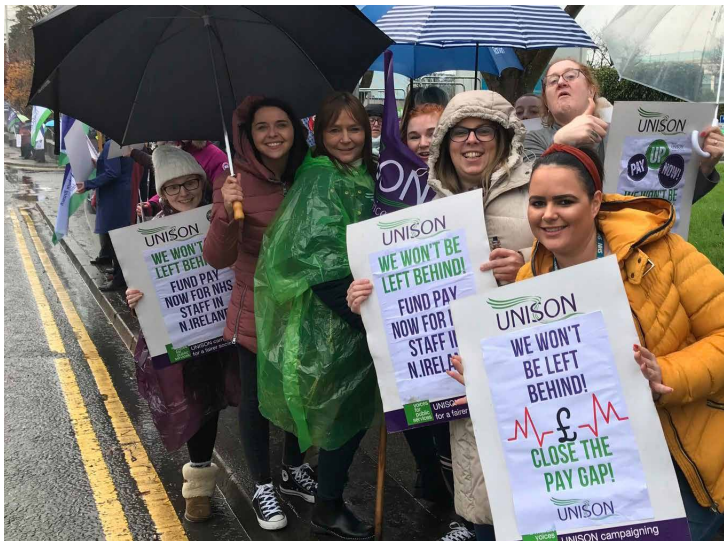
It was reported 20,000 health workers (15,000 nurses) came out on strike from 12 to 24 hours

Photos from the splendid UNISON gallery on the dispute









across all areas and departments. The strike action involved all groups of workers from cleaners, porters, caterers, transport, ambulance staff and nurses.

First ever strike

It was also historic as the Royal College of Nurses (RCN) came out on strike for the first time in its 103 year existence.

This event in itself illustrates the anger and militancy of health workers. Their confidence and strength of their own power was transformed into an uncompromising approach on that day, with every staff member I spoke to across unions stating emphatically that there was no going back!

This has resulted in the RCN Executive agreeing escalating their work to rule action planned for the 8th and 10th January to strike action, with further action proposed for the 20th, 22nd and 24th February. Other unions are currently looking at these dates to coordinate action.

Keep up pressure

It is positive that some health unions have agreed taking strike action again in the coming weeks to keep up the pressure.

This action will be augmented with the likely positive results at the end of January for industrial action ballots on pay from Allied Health Professional organisations (AHP), Royal College of Midwives, Society of Radiographers and Royal Society of Physiotherapists.

Any attack on the strikes by anti-union and Conservative commentators in the mainstream media has fallen on deaf ears across working class communities

It is essential that all health unions and AHPs maintain the momentum and immediately coordinate a series of strike dates to maximise the impact.

Maximum coordination is necessary in this battle, that means not just at the top but at all levels, including cross-union committees in workplaces to ensure that the dispute is democratically controlled by health workers.

There is also a need for increased coordination when it comes to action short of strike action, to cut across any confusion that exists in multi-union workplaces.

There is also no doubt that there is overwhelming support for the health workers dispute across all communities.

Any attack on the strikes by anti-union and conservative commentators facilitated through mainstream media has fallen on deaf ears across working class communities.

This was illustrated during the strike on the 18th, when local people routinely visited picket lines to show support, many bringing coffee, tea and sandwiches etc.

It is likely, given the pressure that is being brought to bear and potential for further action, that a revised pay deal is likely to be offered and maybe accepted by staff. However, it is also recognised that this dispute is not only about pay but also staffing and the provision of gold standard health services.

A win on pay will only augment this demand and see this campaign refocus onto the defence of our publicly-owned health service and opposition of privatisation.

Useful insights on American health care that help understand issues in our NHS

The strange world of US health care offers us a combination of horror stories to remind us how much we still have to defend in our NHS, and occasionally illustrations of more general principles. A recent flurry of studies on the US system has offered us a few of each. JOHN LISTER has dug through them.

The imposition of charges for health care, and especially for hospital care, where the likely charges can be much higher, is known to deter people, especially those on low or no incomes, from seeking treatment – irrespective of their clinical need.

A recent study of the levying of daily "co-payments" for patients receiving hospital care funded through Medicare Advantage in the USA has the dual advantage of confirming the general analysis and explaining some of the obscure terminology used by the US health insurance system.

The impact of copayments

The article, *Association of daily copayments with use of hospital care among Medicare Advantage enrollees,* explains from the outset that:

> **"Cost sharing is a common technique utilized by health insurers to "share" a portion of an enrollee's health expenditures with the enrollee.**
> **"This often takes the form of a payment at the point of service (co-payment) or payment for a fixed percentage of the cost of a given health service (co-insurance). In the hospital setting, this could also be a lump sum payment at admission (a deductible), or a payment for each day in the hospital (a per diem)."**

This is useful reference, as the article delves into the arcane world of US health care, pointing out to the many of us who didn't know that Medicare (the publicly-funded system for providing care for senior citizens, introduced by Lyndon Johnson in the late 1960s) has always levied charges:

> **"The Medicare program has used cost sharing in various forms since its inception in 1965. Medicare enrollees are responsible for 20% coinsurance for physician visits and large inpatient deductibles for hospital admissions, with no cap on out-of-pocket spending."**

In other words even the part of US health care that looks most like the NHS can still be expensive for pensioners to use, and the common factor with all charges is that they deter people:

> **"The imposition of an inpatient deductible in the United Mine Workers Health Plan in 1977 was associated with a 45% decline in the probability of having a hospitalization."**

The paper explains that the fixed fee of a "deductible" is less effective as a deterrent than daily charges, which impact most on those with greatest health need:

> **"A deductible is typically exceeded during the first day of a hospital stay, leaving no financial incentive for a patient to leave the hospital earlier. In contrast, a per diem structure retains an incentive for a patient to leave the hospital throughout his or her stay.**
> **"Thus, changing a plan's benefit structure from a deductible to a per diem could mean lower out-of-pocket spending for beneficiaries with shorter lengths of stay, but greater out-of-pocket costs for hospitalized beneficiaries with longer lengths of stay, and subsequently could lead to decreased utilization."**

In practical terms the change meant that in place of a fixed cost of $376 for a spell in hospital, under the new scheme over-65s who stayed the average 4.4 days would face a bill of $726, with the cost rising each day.

The study concludes, unsurprisingly that the switch to per diem payments did reduce the level of inpatient care for older patients, and that "the financial burden of changing from a deductible to a per-diem falls heavily on seniors with longer hospital stays."

Medicare (the publicly-funded system for providing care for senior citizens, introduced by Lyndon Johnson in the late 1960s) has always levied charges

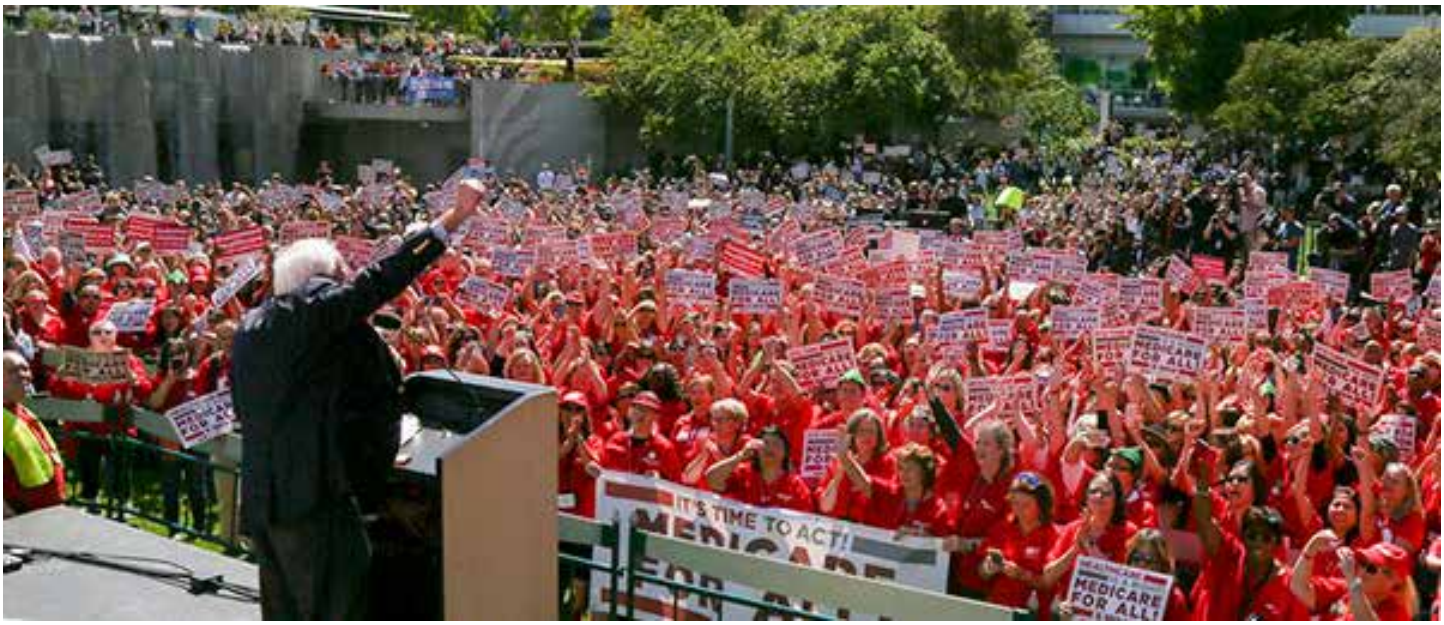
Mergers of hospitals

Another study, this time in the New England Journal of Medicine, looked at the impact on patient care of acquisitions and mergers of hospitals, which has become an increasingly common occurrence in the past decade.

Changes in Quality of Care after Hospital Mergers and Acquisitions looks at the US experience, where of course many hospitals are commercial businesses: but the merger of NHS hospital trusts and foundation trusts has become an increasingly common feature of our health service, and the clinical impact has not been fully evaluated.

The study looks at 246 hospitals that were subject to this process between 2009 and 2013, with almost 2000 hospitals which had not gone through the same changes as a 'control':

> **"we conducted difference-in-differences analyses comparing changes in the performance of acquired hospitals from the time before acquisition to the time after acquisition with concurrent changes**



for control hospitals that did not have a change in ownership."

The findings – which of course in the US have to be viewed in the context of system that (despite decades of experience) still views competition between hospitals as a way to enhance quality of care – are that there was a decline in patient experience and "no detectable" changes in readmission or mortality rates:

"Effects on performance on clinical-process measures at acquired hospitals were inconclusive. Taken together, these findings provide no evidence of quality improvement attributable to changes in ownership."

Overall the authors sum up with a negative conclusion of the impact of mergers that should stimulate some more critical thinking about the value of similar changes in England:

"These findings challenge arguments that hospital consolidation, which is known to increase prices, also improves quality."

Costs – and savings from – introducing a single payer system

A third, even more recent open-access study in PLoS Medicine looks at the costs of switching from the current US system based on private insurance and a multiplicity of insurance companies to a 'single payer' system.

The study, ***Projected costs of single-payer healthcare financing in the United States: A systematic review of economic analyses,*** usefully explains the characteristics of a single payer system, as argued for by Physicians for a National Health Program, and, as "Medicate for all", by Bernie Sanders.

The authors make clear a real single payer scheme would eliminate the private insurers, and eliminate or almost eliminate any "cost sharing" fees to access health care (fees in excess of $5-$10).

As a result it is accepted it would increase the use of health care by many of the millions who at present cannot afford to do so – while bringing down the cost.

"Key elements of single-payer include unified government or quasi-government financing, universal coverage with a single comprehensive benefit package, elimination of private insurers, and universal negotiation of provider reimbursement and drug prices.

Single-payer as it has been proposed in the US has no or minimal cost sharing.

Polled support for single-payer is near an all-time high, as high as two-thirds of Americans and 55% of physicians."

Spending on admin and other aspects of the system adds up to a staggering 30% or more of US health spending, adding up to as much as $935 billion per year.

The researchers searched the academic literature back to 1990 for articles that estimated the costs of this change, excluding studies that gave inadequate technical details or which assumed a substantial continued role of other health insurance.

They found 22 appropriately based articles: and their analysis showed a remarkable level of unanimity, in that 19 of them projected financial savings from the very first year of the new system, while 20 out of 22 "predicted savings over several years".

The main source of the predicted savings was on reduced costs and complexity of administration, along with savings on drug costs.

As we discussed in a previous Lowdown, researchers have shown that wasted spending on admin and other aspects of the system adds up to a staggering 30% or more of US health spending, with estimates as high as $935 billion per year.

Introducing their new study, the authors sum up the grotesquely expensive US system:

"Healthcare costs continue to rise, approaching one-fifth of the economy. In 2018, national health expenditures reached $3.6 trillion, equivalent to 17.7% of GDP.

Government funding, including public programs, private insurance for government employees, and tax subsidies for private insurance, represented 64% of national health expenditures in 2013, or 11% of GDP, more than total health expenditures in almost any other nation.

Higher costs in the US are due primarily to higher prices and administrative inefficiency, not higher utilization."

With such large numbers of Americans backing the idea of single payer after years of frustration with the existing system, the authors of this study are keen to get on and try out the idea which seems to have also secured overwhelming support from analysts:

"The logical next step is real-world experimentation, including evaluation and refinement to minimize transition costs and achieve modeled performance in reality."

The sooner some of these ideas can take shape in reality, the more lives can be saved and the more misery can be avoided for uninsured and under-insured Americans.

THE lowdown

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 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.


THE lowdown

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

Informing, alerting and empowering NHS staff and campaigners

RCP warns of vacancies

Private GP service sets sights on further NHS expansion

Paul Evans

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

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

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 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 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*