The lowdown

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

Why NI funding boost is still not enough for health and social care

After a decade of austerity, the whirlwind efforts by the Johnson government to push through a £36 billion 3-year package of tax increases for the NHS and social care appears to represent a major change of policy.

But while extra money is always welcome, the problem created since 2010, with real terms NHS funding in England each year falling further behind inflationary costs and the needs of a growing population, £36bn is still nowhere near enough to do all the things ministers claim it will do. Successive governments have been digging and deepening a black hole for the NHS and social care – and are now belatedly trying to escape the blame for the consequences, with the increased costs falling on the poorest workers.

With over 7,000 hospital beds in England still occupied by Covid patients and infection levels still high, and 14,000 front line beds that were occupied in 2019 now closed or lying empty as a result of the Covid pandemic, the pres-

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sure on the NHS and its stressed-out staff is enormous.

But the extra allocation to NHS England equates to £15.6bn from April 2022 to 2025 – well short of the £10bn extra for 2022-3 called for by NHS Providers and the NHS Confederation to cover ongoing COVID-19 costs (£4.6 billion); recover care backlogs (£3.5-4.5bn); and compensate for lost 'efficiency savings'. The Health Foundation estimates an extra £17bn is needed by 2024 just to shrink waiting times to 18-week target levels.

A recent joint report from NHS Providers and the NHS Confederation, A reckoning: the continuing cost of Covid-19, drew on a survey of 116 of the 213 trusts covering acute, mental health, community and ambulance services to estimate that Covid has increased the cost of running frontline service by £4.6 bn a year, on top of the extra costs of recovering backlogs of elective care and the need for capital investment – a topic they raise but do not explore.

The report's focus on the Covid-driven extra costs avoids any serious discussion of the extent to which the NHS had been chronically under-funded and waiting lists were growing BEFORE Covid.

It begins by emphasising the massive squeeze on NHS spending under David Cameron and Theresa May's governments, and the inadequacy of the £33.9bn increase to 2024 announced under May and now endlessly quoted by the Johnson government:

"Between 2010 and 2019, the health service experienced the longest and deepest financial squeeze in its history. The five-year funding settlement announced in June 2018, while welcome, was only enough to enable the NHS to keep pace with increasing demand – it was never sufficient to fully recover performance levels or deliver truly transformative change."

In social care, where the funding cuts have been even more severe, 95% of providers told ITV news they are unable to take on all the new clients in need of their help, while many more are unable fulfil their contracts for lack of staff.

Yet just £5.4 billion (£1.8bn per year) is allocated to social care over 3 years, supposedly to solve the chronic problems of the fragmented, privatised and dysfunctional social care system, where staff shortages are estimated by the GMB to rise as high as 170,000 – driven by low pay, stressful work, low status and turnover rates of 30% for nursing staff.

This is clearly nowhere near enough to address all of the problems – nor does a new formula for means testing charges for social care and capping personal spending at the eye-watering level of £86,000 address any of the issues that need reform.

£6 billion is to be divided between the devolved administrations in Scotland, Wales and Northern Ireland, where health and social care are already integrated – leaving £30 billion for England.

An extra £9bn is allocated to the Department of Health and Social Care for other purposes including training, vaccines.

Rapid worsening of the situation

Meanwhile, a new report from the Association of Directors of Adult Social Services indicates a rapid worsening of the situation, with nearly 300,000 people awaiting social care assessments, care and support or reviews, up by just over a quarter (26%) over the last three months: 11,000 of them have been waiting for more than six months, up by over 50% in 3 months.

The extra money represents a partial change of heart from Chancellor Rishi Sunak, who once said the government would give the NHS whatever it needed to cope with the Covid crisis, but who was more recently reported to have told colleagues that Covid-19 handouts "can't go on forever".

For an understanding of financial issues in the NHS it's worth reading the recent update from Nuffield Trust's Sally Gainsbury Checking the NHS's reality – the true state of the health service's finances. In a closely argued comment contrasting the "parallel reality" of Treasury, NHS England and commissioners' assumptions with the actual situation facing NHS providers.

While noting the additional costs faced by the NHS (£2 billion a year to even start to fix the elective waiting list, and perhaps a further £6.6 billion needed from October onwards to deal with ongoing Covid admissions to hospitals) Gainsbury also highlights the £2bn shortfall of funding that has been a feature of NHS plans every year since the 2015 Spending Review:

"The same reality gap is present each time: activity assumptions understating the cost pressures brought by increasing patient numbers by around £1 billion each year, accompanied by a further £1 billion or so over-optimism on the scale of costs that could be permanently (i.e recurrently) removed from providers' cost bases."

She goes on to calculate what how the underlying income and cost base of providers would have changed by now had it not been for the pandemic, estimating that the current funding gap has widened to £5 billion.

The gaps and deficits are no accident: they are a result of deliberate policy decisions – and patching up the NHS and social care is now so costly even £12bn a year falls well short of what is needed.

John Lister

National Insurance increase for care funding unfair

After a weekend of torrid speculation the PM has confirmed government plans to raise National Insurance for working people and businesses to pay for increased ring-fenced funding for the NHS and social care, breaking his party's promise of no tax rises made at the last election.

This is wrong on so many levels. Not only is the amount be raised pathetically inadequate – with NHS bosses telling the Guardian they are braced for an increase of just £5 billion next year, having argued in detail why a minimum £10bn is required to meet the increased costs of Covid and the need to bring down waiting times and reduce waiting lists – but national insurance is the most regressive way to raise tax income.

Rather than raise a combination of capital gains tax, corporation tax, or tax private wealth, financial speculation or tax-dodging corporations, this tax hike hits the poorest.

Tax expert Richard Murphy has pointed out that the government's own table of rates, allowances and reliefs shows how this tax targets those on lower pay, starting on levels of income below the income tax threshold – but proportionally people with incomes above £50,000 a year pay drastically less

Indeed many of the wealthiest people are exempt from it. NIC is not paid at all on unearned income, whether from interest, dividends, rents, trusts or other sources. Retired people, however well off, and even if they work, do not pay it. And many self-employed people with their own companies can avoid significant NIC liability.

So, this is a tax on those in paid employment, and those least likely to be able to afford a tax increase, including people on very low incomes who are already suffering cuts in Universal Credit and facing increased fuel poverty. Worsening their plight is likely to undermine their health and increase pressure on the NHS.

The new tax has been called a health and social care levy possibly to help make it sound less like a tax, but Johnson will also have been spurred on by public polling. 55% of people backed a rise in national insurance and 51 per cent a rise in income tax.

However we can now see that the long-promised Johnson plan to "fix the crisis" in social care, involves only "capping" the total costs payable rather than any proposal to deliver the service free at point of use, along the line of the tax-funded NHS. Those with assets less than £20,000 pay nothing towards their costs but those with assets between £20,000-£100-000 will still pay something towards care fees - depending on contributions from their local authority, who will receive a share of the proceeds of the new levy.

Responding to the PM statement in Parliament Sir Keir Starmer said: "Under the Prime Minister's plans the quality of care received will not improve. There is no plan for that, people will still go without the care they need, there is no plan for that. Unpaid family carers will still be pushed to breaking point, there is no plan for that."

Sir Ian Duncan Smith was among Tories critics labelling the changes a sham for not reforming the social care system.

Recruitment crisis remains

Above and beyond the issue of funding the problems of the increasingly dysfunctional, largely privatised social care system have been significantly worsened since Covid and Brexit, with an exodus of staff and increased problems in recruiting to low-paid stressful jobs often at unsocial hours.

A survey for ITV News report on September 2 found 78% of providers who responded said recruiting carers is the hardest it has ever been. Because of the staffing crisis, 95% of providers said they are unable to take on all the new clients in need of their help, while 30% of the 843 providers surveyed said they are handing back some, or all, of their care to local authorities because they can no longer fulfil their contracts. ITV News reported having seen lists of people who are waiting more than three months to have a provider assigned to them.

So while NHS Providers step up the pressure for increased NHS funding to allow hospitals and mental health service to get back on track, and the Health and Care Bill seeks to remove the legal requirement to assess vulnerable patients' needs prior to discharge, the lack of functional social care is likely to block any more rapid discharge of patients.

Tackling part of the problem, and denying the scale and complexity of the issues that have arisen from a decade of under-funding and rounds of ill-conceived legislation limiting international recruitment, still leaves a health and care system deep in crisis.

John Lister

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GPs endure relentless workload and abuse

Flu vaccine and blood test tube shortages – along with a 'new' access improvement programme* – look set to further stress a primary care network already hamstrung by workload and recruitment issues, abuse from patients, attacks by the media and mixed messaging from NHS England.

Meticulous preparations at GP surgeries across England for this winter's flu vaccination programme have been thrown into disarray by a two-week delay, thanks to "unforeseen road freight challenges" at supplier Seqirus and a lack of contingency planning by central government.

These 'challenges' relate to a shortage of HGV drivers – caused by post-Brexit immigration rules and covid restrictions – and mirror the supply chain issues experienced in recent weeks by retailers like Tesco and fast-food outlets such as McDonald's and Nando's.

Meanwhile, with little warning, NHS England (NHSE) told GPs last month to cancel all non-essential blood tests until mid-September, owing to a production shortfall at blood test tube manufacturer Becton Dickinson.

Both problems are predicted to cause administrative nightmares for surgery staff, as well as extra work for already stretched GPs, and could increase the likelihood of abuse from patients.

On the question of testing, British Medical Association (BMA) council deputy chair Dr David Wrigley told online newsletter Pulse last month, "Many GP practices will now have to spend hours assessing which already scheduled tests can or cannot be cancelled and this takes time away from frontline patient care when it is most needed. Cancelling tests makes patients anxious and can mean a missed diagnosis."

And Dr Richard Vautrey, BMA GP committee chairman, predicted that the delay to the flu vaccination programme will only add to practices' already unsustainable workloads, and is likely to cause unnecessary anxiety for patients.

Workloads and recruitment

In fact those relentless workloads – driven by an ongoing recruitment crisis predating the pandemic, and exacerbated by a post-covid surge in demand – are now an everyday fact of life for most practices, and have inevitably led on occasion to patients having to wait for non-urgent appointments.

A survey of London GP practices in June this year, for example, revealed that more than half described the demand for appointments as unmanageable – and showed that half of them had vacancies too.

Across the UK the number of fully qualified, full-time equivalent GPs per patient has dropped by 10 per cent in the past five years, and vacancy rates nationally show one in seven posts are unfilled. There are also now fewer GPs per head of population in England than there are in comparable countries in Europe.

Even the NHS 111 helpline reported last week being short of 70,000 GP appointment slots because of continuing high levels of demand.

But despite that, GP appointments are now actually up 31 per cent compared with pre-pandemic levels, and more than 50 per cent of appointments have been delivered face-to-face throughout the pandemic, according to figures from NHS Digital.

Nevertheless, last week the Health Service Journal reported that GPs at one of the largest GP groups in England – Modality Partnership – were regularly breaching daily 'safety levels', with average number of daily patient contacts (face-to-face or phone consultations) up from just over 20 to nearly 50. The BMA puts the 'safe' number of contacts at 25-30.

That's why the Royal College of General Practitioners (RCGP) in July called for a five-point emergency rescue package for general practice – entailing the recruitment of 6,000 more GPs (as already pledged by the Tories during the 2019 general election campaign) and 26,000 extra practice nurses and receptionists – and why last month the BMA followed suit by launching 'Support Your Surgery', a public campaign to rally support for GP surgeries and push for increased government investment.

Abusive patient behaviour

Verbal and physical abuse of surgery staff has taken off rapidly during the pandemic.

A survey taken last October by the Medical Protection Society (MPS) revealed that more than one in three doctors had been the victim of such abuse by patients or their relatives in the preceding six months after the first lockdown began, and that many instances stemmed from a mistaken belief that GP practices were closed. Similar research, undertaken by the MPS last month, showed that staff at three in four surgeries had experienced verbal abuse.

Comparable findings emerged from a BMA survey of 2,400 doctors, also conducted last month. According to the association's research, more than a third of doctors had experienced verbal abuse and threats – as well as violent assault – with GPs the most likely to be targeted. Nearly 70 per cent of GPs interviewed said such abuse had worsened over the past 12 months.

And according to a report in the Independent, again last month, some surgeries have received bomb threats, others have been daubed with graffiti, while staff at one practice fell victim to anti-vaxx hate mail and were sent text messages describing them as 'Nazi b******s'.

It's no wonder then that more GPs referred themselves to the Practitioner Health programme, a service providing mental health support to doctors, in the past 12 months than in the previous nine years in total.

Right-wing media messaging

Much of the abuse suffered by GPs and surgery support staff stems from the false perception among many patients that practices are closed and appointments are unavailable. It's a perception that's been widely promoted by several right-wing media outlets – and subsequently amplified on social media sites like Mumsnet – since the pandemic began. And it is gaining momentum.

Two weeks ago one journalist at the Mail seemed to be outraged simply because GPs were able to earn the same from virtual appointments conducted from their homes as they could from face-to-face appointments in surgeries, backing up the accusation with a pointed reference to the average GP's salary.

Two follow-up pieces have appeared in the Mail over the past few days: the first was a 'special report' claiming to 'lay bare the grim truth' and seeming to suggest GPs might be "obstinate and idle"; the second was a comment piece headlined, "A betrayal of the NHS: Janet Street-Porter says the only people GPs are keeping healthy with their scandalous refusal to meet patients face-to-face are themselves".

Equally 'on message' were three editorial pieces in the Telegraph, appearing over the same weeks as the Mail stories, and featuring such headlines as: "Are GPs who refuse face-to-face appointments breaking the law?", "Time to turn the heat up on GPs who won't see us face to face" and "Vets serve pets better than GPs do [the] public".

Both titles seem to have forgotten that NHSE actually mandated a move to 'total triage' in March last year – a move dependent on remote rather than face-to-face consultations, and described at the time by former health secretary Matt Hancock as "remote by default".

They may also not have noticed that last week NHSE actually instructed primary care providers across England to maintain covid infection protection and control procedures – despite them being relaxed across most other settings last month – in a move that is said to have led to thousands of appointments being cancelled through no fault of GPs.

Misrepresentation of GPs' performance has gained traction since the pandemic began. An analysis by Pulse earlier this year, looking at negative media coverage of GPs in 2020, found that nearly half of the articles appearing suggested practices were either shut or providing poor access to appointments, and claimed GPs were 'refusing' to work or should be 'back at work'.

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Millions go without mental health support

There are around 8 million people in England that are denied access to mental health services because they do not have severe enough symptoms to get put onto a waiting list, according to NHS leaders.

As the official waiting list stands at around 1.6 million people, this means there are now almost 10 million people in England struggling without adequate help and support from mental health

The 8 million figure is based on the known prevalence of mental health conditions and the thresholds dictating who gets access to treatment; NHS England considers it an accurate figure for the number of people who are missing out on care because services are not adequate. services.

These 8 million are also unlikely to receive help any time soon unless the upcoming funding settlement for the NHS is adequate. Indeed, NHS Providers, which represents the NHS trusts, warns that any progress that has been made in improving mental health services over the past few months to help those who actually reached the waiting lists will also be lost without an adequate increase in funding.

Saffron Corderoy, Deputy Director of NHS Providers, noted that the review:

"must make good on commitments to date which, despite years of underinvestment and the enduring care deficit, had started to improve services and experiences for mental health

patients. Critically the settlement for mental health must also recognise that mental health trusts are treating more patients than ever before and that COVID-19 has added a significant challenge into the mix in terms of increasing the numbers seeking help and the complexity of the help needed."

Funding calls

The consensus from healthcare leaders from NHS Providers, representing NHS trusts and the NHS Confederation, which brings together all providers of care in the NHS, is that the NHS needs £10 billion more per year to address the backlog and increase in demand due to the pandemic, but on Monday the Chancellor Rishi Sunak confirmed an extra £5 billion, amid strong calls for more a realistic funding settlement from across the NHS.

In 2020 when it became obvious what a devastating effect the pandemic was having on the nation's mental health, there were calls for extra funding. In the November 2020 spending review, the Chancellor gave an extra £670 million, but Head of Policy and Campaigns at the mental health charity Mind, summed up the view coming from many similar organisations:

" [the funding] is some way short of estimates that due to increased demand mental health services will require more than £1bn a year for the next three years, to deal with the long term fall out of the pandemic."

Pandemic effect

Services for under-18s in particular have seen a dramatic increase in demand since the pandemic began. The recent NHS Confederation report - Reaching the tipping point: children and young people's mental health - notes that as many as 1.5 million children and young people may need new or additional mental health support as a result of the pandemic, but this is likely to be an underestimate. The official waiting list contains just 374,000 under-18s.

The area of eating disorders has been singled out as one that has seen a particularly high increase in demand. In August a new analysis by the Royal College of Psychiatrists found that at the end of the first quarter (April, May and June) of 2021/22, 207 patients were waiting for urgent treatment, up from 56 at the same time last year.

A further 1,832 patients were waiting for routine treatment, up from 441 at the same time last year. And 852 patients received urgent treatment, compared with 328 in the first quarter of 2020/21. However, in May 2021, an NHS Providers survey found 85% of trust leaders said they could not meet demand for children and young people's eating disorder services.

Then there is the impact on the NHS as a whole - FirstCare, which monitors absences in the health service reported that there were 13,000 NHS staff off work because of mental health issues in May 2021 – a 55% increase on the previous year - and in June the increase was 42%.

Although the problems within mental health services have been exacerbated by the pandemic, a decade of underfunding by Conservative governments has resulted in bed cuts, falling staff numbers, an infrastructure that is no longer fit for purpose, and A&E being used as the first port of call for patients in crisis, due to a lack of any other option.

The Lowdown has been reporting on the crisis situation in England's mental health services for some time now. Although extra money has been ploughed into services in recent months, the concern is that it will not be enough to address even pre-pandemic issues, let alone the increases in demand due to the pandemic. NHS Providers notes that demand now significantly outstrips supply despite the fact that services are treating more patients than ever before.

As a result many of the issues that needed to be addressed in pre-pandemic times have got worse - the long waits for care, bed occupancy above safe levels, inappropriate out-of-area placements, including for young people, where treatment is miles away from home, and when patients are eventually seen, more and more of them are at a crisis point.

What is needed?

The service needs more staff, more beds, and an infrastructure that can cope with the demand; much of the NHS' mental health service estate needs updating and repair. NHS Providers notes that services need "critical capital investment to tackle the most immediate challenges facing the mental health estate" plus "significantly more funding" to "recruit enough staff with the right skills, expand community services to avoid inpatient admissions where possible, increase bed numbers to bring care closer to home and to tackle the ever growing backlog of care caused by the pandemic."

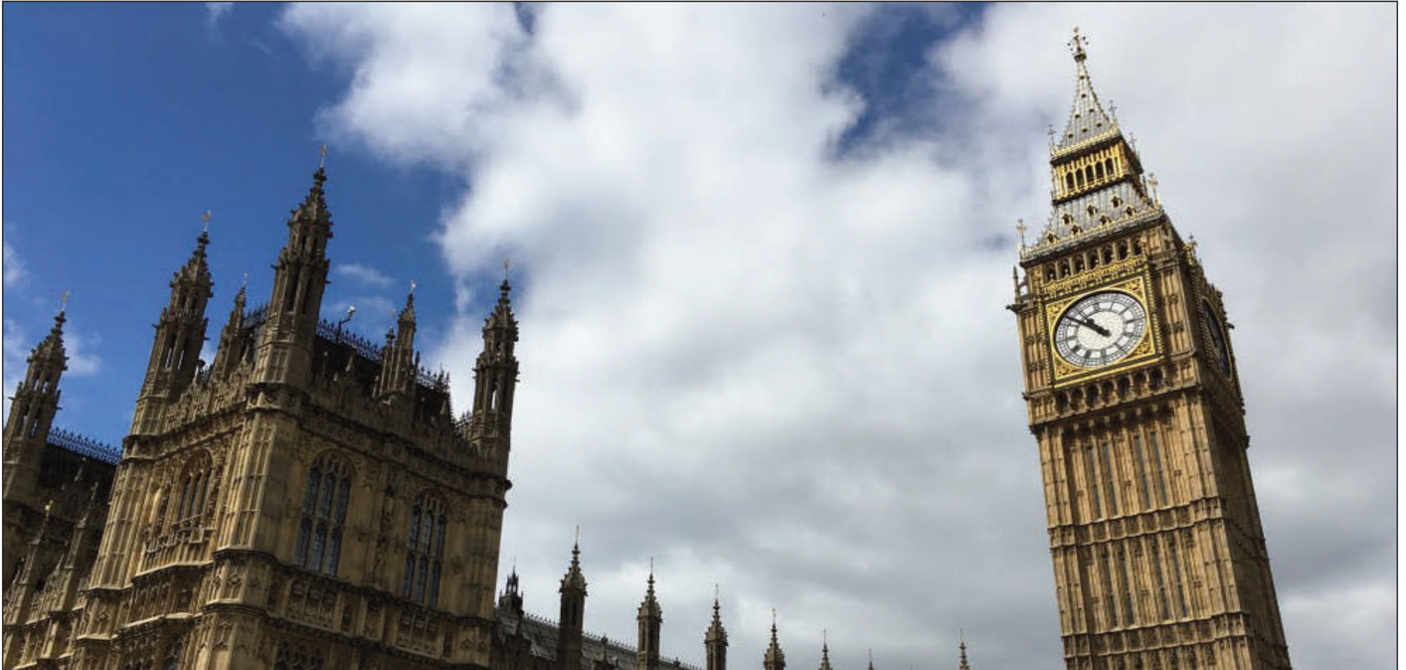
A survey conducted by the British Medical Association (BMA) just before the pandemic began found 63% of mental health staff worked in a setting with rota gaps, and 69% of these said such gaps occurred either most or all of the time.

According to The Health Foundation the number of mental health nurses dropped by 8% in the 10 years to June 2020, and there was a 39% fall in learning disability nurses.

The latest figures for staff vacancies released in August 2021 from NHS Digital show 93,806 vacancies, with 38,952 of them for registered nurses, with a major problem in the mental health sector.

Sylvia Davidson

Health and care bill takes deep flaws into committee stage



As the Health and Care Bill moves into the committee stage where the detail of the bill is closely examined many people from different points of view are coming to the conclusion that it has deep flaw.

Here are some of the main points raised by commentators, campaigners and trade unions.

It does not address the major problems confronting health and care systems after a decade of austerity funding – and has nothing to say about social care. It will create disruption at a time the NHS needs to focus on recovery after Covid.

It removes some important aspects of the Health and Social Care Act 2012 and associated regulations – but it does not prevent or reverse privatisation, nor does it extend to services which should also be delivered by NHS staff – cleaning, portering, catering, etc.

It doesn't establish the NHS as the default provider when existing contracts come to an end. Nor does it prevent competitive tendering, or the extension of "framework contracts" which can award contracts without competition or tender to private companies (or other providers) from a pre-approved list.

There is no proper protection against more crony contracts awarded without proper oversight. Nothing in the Bill would prevent more trusts – or ICBs – setting up subsidiary companies to dodge taxes, evade scrutiny or undermine terms and conditions of staff.

The Bill gives extensive new powers to the Secretary of State, but drastically reduces the voice of local communities. Making every NHS organisation inform the SoS every time they think about changing a service is a bureaucratic nightmare that should be dropped. Other new powers include taking decisions over professional regulation that are currently controlled by professional bodies.

After five years of top-down pressure to merge Clinical Commissioning Groups (CCGs) created by the 2012 Act, the Bill abolishes the remaining CCGs, leaving England's NHS controlled by just 42 Integrated Care Boards (ICBs) – the fewest "local" bodies since NHS reforms began almost 50 years ago.

It could potentially allow people associated with the interests of private companies to sit on ICBs and Integrated Care Partnerships but does not require health workers, directors of public health, patients, or public to be represented. This leaves the danger that strong vested interests such as a large Foundation Trust could dominate – and services such as mental health or community care could be pushed to the sidelines.

The single local government seat per ICB would leave no real voice for local authorities at the "place" level. Indeed the Bill makes no reference to "place" and has no provisions to implement NHS England's repeated promises of delegation of decision-making to 'place' level. Instead, each ICB would set its own constitution.

The Bill also proposes to change the law to remove the legal requirement to assess patients prior to discharge. While some pilot

schemes have deployed additional resources to facilitate "discharge to assess" – and there were specific reasons for suspending the law during the pandemic – the general picture is of grossly inadequate community, primary care, and social care services raising a real risk of patients in many areas merely being dumped without support.

The Bill curbs some of the "freedoms" of Foundation Trusts (FTs) and scraps what proved to be unachievable requirements of the 2012 Act for all NHS trusts to become FTs. But this leaves FTs outside of any "integration" process – not subject to direction by the ICBs or by NHS England. It also leaves the 2012 Act provision allowing FTs to expand their private patient and non-NHS income up to half of the FT's total revenue without any proper scrutiny.

This is an obstacle to genuine integration of services since some FTs would be free to go their own way, and focus on non-NHS activity at a time when NHS resources are stretched to the maximum. Some FTs, like Oxford University and Royal Marsden are already doing so.

A new NHS Payment scheme is proposed in the Bill to replace the current national tariff of prices for patient care with locally-negotiated prices – which poses the danger of a postcode lottery for patient care, with some ICBs leading a race to the bottom on quality, and a revival of price based competition.

Some restrictions should be put into the Bill to ensure a genuine move away from market-based mechanisms like payment by volume and back to block contracts based on nationally-decided costings. Competition based on price should not be permitted.

The scale of the Tory majority makes outright defeat of the Bill out of the question, so the focus for ongoing campaigning has to centre on making the case for amendments to tackle the main negative elements of the Bill.

Whilst many concerns will be raised as the Bill progresses, campaigners need to prioritise issues that can attract a wide range of support.

Tha passage of the Bill

In Parliament Labour oppose the bill, but there are unlikely to be enough Tory rebels for it not to pass. Attempts to amend it are being made and could attract support from some Tories and within the Lords, especially as the government is keen to push it through quickly, opening up some opportunities for concessions.

The bill entered the Commons for its committee stage on 7 September, where each clause is examined. Changes will be presented for debate and votes in the Report stage, before the Third reading and its passage into the Lords where the process is repeated.

Here are some of the areas where amendments are likely to be sought:

Competition procurement and privatisation

NHS to be default provider as any existing outsourced contracts with Trusts or CCGs expire: only where ICS can demonstrate NHS providers unable/unwilling to provide services may services be outsourced or re-tendered.

To avoid a race to the bottom on quality (as happened with hospital cleaning in the 1980s) only companies paying at least NHS pay, terms and conditions should be allowed to bid for contracts.

Duties of Secretary of State:

Those who campaigned against the Lansley Bill will be in favour of the SoS having powers over, and being held directly responsible for the NHS, as was clear before 2012. But not all of the many new powers are appropriate, and there must be proper parliamentary oversight of their use.

Any new powers must be coupled with the restoration of the pre-2012 duties of the Secretary of State, which, given the new structure of the NHS, should also apply to NHS England and ICBs, through which he carries out these duties.

Trusts and Foundation Trusts

Amendments to the 2012 Act should put FTs on equal status with NHS trusts (a level playing field), make them subject to direction in the same way, reimpose the cap on non-NHS income, and require both FTs and NHS Trusts to publish income AND EXPENDITURE details of any private patient activity to expose the real cost to the NHS.

Loss of local accountability

ICB chairs, who under the Bill would have considerable powers, but would be appointed by NHS England subject to approval by the SoS, should instead be ELECTED in a system analogous to Mayors or Police and Crime Commissioners.

ICBs and Partnerships must be barred from including any private sector representatives on their Boards or decision-making roles. ICB non executives must be appointed through a fair process focused on respecting diversity and overseen independently, and include mental health, public health and patient representation.

The Bill needs to be explicit that ICBs and ICPs must meet in public, make arrangements for remote access, publish all the papers in good time and they must be prevented for using any argument of commercial confidentiality to avoid providing information.

Funding allocations to places and providers must be subject to local democratic challenge, and local access to the full range of NHS services should be guaranteed to all communities, with any change to local services subject to oversight by each Council's Health Scrutiny function.

Professional regulation

New powers over professional regulation should not be given to the Secretary of State unless the Bill imposes some stronger oversight by parliament and some test to apply as to the overall value of any change.

John Lister

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Expansion of pharmacies' clinical offering will do little to offset crisis in general practice

The move by the NHS community pharmacy sector to bolster its clinical offer to patients by expanding into hypertension case-finding and smoking cessation services is a welcome development, but the wider crisis in primary healthcare provision remains.

From October, more than 11,000 pharmacies which have signed up to the 'community pharmacy contractual framework' (CPCF) – a five-year deal already agreed by NHS England (NHSE), the Department of Health & Social Care (DHSC) and the Pharmaceutical Services Negotiating Committee (PSNC) – will offer the first of these services, providing blood-pressure checks to people aged 40 and over, under the mantle of hypertension case-finding.

According to NHSE, this service simply involves a free

blood-pressure check as part of a 10-15 minute consultation with a trained member of the pharmacy team, following which patients "may be invited to take home a blood-pressure monitor" to take further readings, or alternatively they may be referred on to a GP.

Whether the roll-out of this quick-turnaround service, piloted last autumn, turns out to be an effective move only time will tell – NHSE claims that 3,700 strokes and 2,500 heart attacks could be prevented, and around 2,000 lives saved, over the next five years as a result of its introduction – but GP surgeries, by contrast, often recommend taking readings at home over the course of seven days to gain a more reliable idea of a patient's blood-pressure.

The second service, piloted last November and scheduled for roll-out next January, is a smoking cessation programme, offering free advice and support sessions over 12 weeks with a trained member of a pharmacy team, for smokers recently discharged from hospital.

Costs breakdown

While both initiatives are clinically driven, free at point of access for patients, and therefore come with considerable PR benefits for whoever offers them, neither are provided free to the health service. All NHS community pharmacies – from small independents to national chains – are private companies and therefore get paid extra for running these new programmes, on top of the income they receive for operating existing services such as dispensing prescriptions.

In the case of blood-pressure checks, pharmacies are paid a set-up fee of £440, plus £15 for each clinic check and £45 for each ambulatory monitoring (which involves using a body-worn device over a 24-hour period). Target-driven incentive fees of up to £1,000 are also on offer. For the upcoming smoking cessation service, the set-up fee is even higher, at £1,000, while consultation fees vary between £10-£40.

The DHSC's current 'vision' for the five-year contractual framework under which pharmacies provide these and other services to the NHS is for these commercial interests to become "more integrated in the NHS [and to] provide more clinical services".

This builds neatly on NHSE's stated ambition for a new service model, outlined in the NHS Long Term Plan, to boost "out of hospital care" by dissolving the "historic divide between primary and community health services".

Echoing this ambition, in its press release about the hypertension case-finding and smoking cessation launches, pharmacy trade body PSNC said these new 'advanced' services "help to embed community pharmacies even further into the NHS in line with the sector's vision for its future".

It's questionable whether patients will ever trust pharmacists as much as they would their GP, however, despite all the positive press coverage last week on the launch of the blood-pressure checking service – and despite the King's Fund thinktank describing community pharmacy as "one of the four pillars of the primary care system in England".

To consider why, one only has to look at NHSE's pharmacy staff toolkit guidance on 'minor illness' pathway consultations offered by community pharmacists. This reveals that training courses for these consultations are not mandatory, and that pharmacists must only "be satisfied that they are competent to provide [them]".

But with many GP surgeries still restricting in-person access during the pandemic, following former health secretary Matt Hancock's announcement last year that all medical consultations should henceforth be "remote by default", CPCF's latest initiatives were perhaps to be expected, especially as NHSE has recently – allegedly –been conducting 'negative briefings' suggesting GP practices had simply shut down for the duration.

Evidence actually points to surgeries opening up again, however, with GP appointments up 31 per cent compared with pre-pandemic levels, and more than 50 per cent of appointments delivered face-to-face throughout the pandemic, according to figures from NHS Digital.

Focus on primary care instead

Those figures nevertheless mask a profession that is in crisis: the number of fully qualified, full-time equivalent GPs per patient has dropped by 10 per cent in the past five years, and vacancy rates show one in seven posts are unfilled – all this against a background of rising patient registrations, an ageing population, trainees experiencing burnout because of the pandemic and increasing numbers of patients testing positive for covid.

This situation led the Royal College of General Practitioners in July to call for a five-point emergency rescue package for general practice, and just last week the British Medical Association followed suit by launching 'Support Your Surgery', a public campaign to rally support for GP surgeries and push for increased government investment.

With primary care in such urgent need of support, simply adding blood-pressure monitoring and smoking cessation to the pharmacist's repertoire – and coincidentally boosting the commercial sector's role in the health service – comes across as an empty gesture by the DHSC and NHSE. Backing GP surgeries with the investment they need instead would surely have a greater impact on the nation's health.

Martin Shelley

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Johnson's plan to build 40 hospitals yet to stand-up

From the time he took over as Prime Minister, Boris Johnson has been banging on about building new hospitals. He promised it in the summer of 2019, and again at party conference, and again in the manifesto for the 2019 general election, which stated:

"On top of more money for the NHS every year, we're investing in hospitals so that our brilliant doctors and nurses have the facilities they need to give patients the best possible care.

We're providing £850 million for 20 hospital upgrades, £2.7 billion for the first six new hospitals, and seed funding so that work on 34 more can make progress."

In November 2019 The Lowdown questioned how realistic the promise might be:"It's hard to understand from this over-egged hyperbole that all the Johnson government has done is provide £2.7 billion to fund just **SIX** new or refurbished hospital projects.

"£100 million is also provided as "seed funding" for 21 trusts to draw up plans for another 34 hospital projects – which will potentially cost another £10 billion or more – after 2025.

"This is a long way from being the biggest hospital programme in a generation: from 1997 onwards Tony Blair's government built well over 100 – albeit funded through PFI.

"It's also questionable whether the 34 future projects will ever get beyond the planning stage, since they would need to be agreed and funded by a future government after at least one further election, during or after 2025."

The Lowdown broke down the listed projects: six "new hospitals" were to be a new £400 million "major acute" hospital for Epsom & St Helier trust; a new hospital to replace the ageing Whipps Cross Hospital in north east London; new hospitals to replace Watford General and Harlow's Princess Alexandra Hospital; a reconfiguration in Leicester to reduce from three sites to two, and new wings and 'sympathetic redevelopment' of the Grade I listed Gilbert Scott Building for Leeds Teaching Hospitals.

In addition 21 hospital trusts receiving seed funding accounted for up to 38 "new hospitals" although many of these would clearly not be much more than refurbishment or additional new wings.

These were listed as: Cambridge (Addenbrookes); East Sussex (Conquest & Eastbourne District Hospitals); Hampshire (Royal Hampshire & N. Hants Hospital); Hillingdon Hospital; Imperial College (Charing Cross, St Mary's and Hammersmith); Lowestoft (James Paget) Kettering General; Lancashire (Royal Preston); Milton Keynes Hospital; North Devon District Hospital; Nottingham (Queens Medical Centre, Nottingham City Hospital); North Manchester General Hospital; Plymouth's Derriford Hospital; Reading's Royal Berkshire Hospital; Royal Cornwall Hospital, Royal United Bath Hospital; Musgrove Park Hospital, Somerset; Torbay District Hospital, Devon; Morecambe Bay (Royal Lancaster Infirmary, Furness General Hospital); West Suffolk Hospital; and 'up to 12 community hospitals' for Dorset Healthcare.

Notably this list did not include any projects already ongoing. But a year later the whole story had changed. A major press release in October 2020 stated:

"The Prime Minister today confirmed for the first time that 40 hospitals will be built by 2030 as part of a package worth £3.7 billion, with 8 further new schemes invited to bid, delivering on the government's manifesto commitment."

This was followed by a completely different list, including eight schemes that had not been anywhere to be seen in the initial 'fake forty':

Four were described as "In build": Midland Metropolitan Hospital, Sandwell and West Birmingham; Cumberland Cancer Hospital; Royal Liverpool Hospital; 3Ts Hospital, Brighton;

Four more were "Pending Final Approval": Moorfields Eye Hospital, central London; Northgate Hospital, Morpeth; Major Trauma Hospital Salford; and a new "Defence and National Rehabilitation Centre," in Loughborough.

The six funded schemes were included, and then 25 jumbled schemes (5 of which were Dorset community hospitals), plus a newly announced rebuild of Shotley Bridge hospital in Durham, making 40.

The same press release then announced for the first time that there would be a "Competition for 8 further hospitals including new Mental Health Hospitals". That competition eventually opened up on July 15 and closes this month, with the winning schemes not revealed until next spring.

However the newly revised version of events in the recently leaked New Hospital Programme comms 'Playbook' (which tells Trust bosses what they must say, and how they must clear any press releases or publicity with the 7-strong national Comms team before going public) contradicts the October 2020 Press release, and states:

"Currently, the national programme comprises eight pre-existing schemes and 40 new hospitals, totalling 48 hospitals." It quietly drops in the fact that only 32 of the 40 have been decided, with the other 8 yet to emerge from "expressions of interest".

Of the list of 32 projects which the Playbook insists must all be described as "new hospitals" at least 11 are clearly additional or refurbished wings or units alongside the main hospital, and five more are small-scale community hospitals with limited services.

The Playbook has been criticised by leaders of two professional bodies seeking to uphold standards in public relations. Chartered Institute of Public Relations president Mandy Pearse said: "Accuracy and honesty in public sector communications are important in maintaining public trust. This comment within the Playbook is ill-judged."

Public Relations and Communications Association chief Francis Ingham told PR Week: "It is important that public communications are factual and neither misleading nor exaggerated. To any normal person, a new wing does not equate to a new hospital. In the interests of public confidence in such announcements, we would urge honest, straight-forward accuracy."

Neither honesty nor accuracy are to the fore in the spin doctors' Playbook, which also insists that despite the very obvious delays, fresh questions about the affordability of even the "pathfinder" schemes, and lack of any visible progress, NHS CEOs have to always state that the 'new hospital' plans "remain on track."

It divides the various schemes into five "phases":

Phase 1 – *"In-flight"* schemes – that are in construction or shortly to start construction and are currently anticipated to complete construction between 2021 and 2025.

Phase 2 – *"Agile"* schemes – are smaller projects that are flexible in delivery and have the potential to complete construction earlier in the decade – currently expected to complete 2024-26.

Phase 3 – *Pathfinder* schemes – larger and more complex schemes whose plans are "relatively advanced" and "currently anticipated to start construction between 2023-24 and complete in the period 2026-28."

Phase 4 – *Full Adopter* schemes – will be delivered "in the latter half of the decade"

Phase 5 – *"Next eight"* schemes – "to be identified under the current open process and delivered in the latter half of the decade".

But whichever way the story is now spun, chopped or changed, two factors have remained as constant:

NOT ONE new hospital plan has yet been finalised,

And the bill for backlog maintenance for hospitals not scheduled for any new building has soared to £9 billion, with a worsening plight for the dozen or so hospitals built in the 1970s using reinforced autoclaved aerated concrete planks.

Among the hospitals affected by the crumbling concrete are Crewe's Leighton Hospital (Mid Cheshire); Hinchingbrooke (North West Anglia FT); Wexham Park (Frimley Health FT); James Paget Hospital, Lowestoft; Queen Elizabeth Hospital, Kings Lynn, and West Suffolk Hospital (Bury St Edmunds)

Several of these hospitals are in such a dire state that it could be cheaper to knock them down and rebuild. In the most recent backlog maintenance statistics, for example Mid Cheshire Hospitals abruptly announced a massive £373.9m backlog, with estimates that it would take 15 years and cost £555m to replace all of the crumbling planks, while West Suffolk Hospital (the only hospital of this type on the list of 32 new hospital projects) reported a monster backlog of £634.9m, and the estimated cost of repairing the roof of Queen Elizabeth Hospital in Kings Lynn is £500m.

Rishi Sunak appears committed to an austerity agenda. But unless he makes a massive U-turn to allocate billions more in capital as well as revenue to the NHS there is no way that all the many Comms staff working for the NHS at local and national levels can spin their way out of this growing crisis which affects so many areas.

Nor will spin hide the seemingly inevitable failure of the Johnson government to deliver its keynote manifesto pledge.

John Lister

THE lowdown

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Lack of support from NHSE

NHSE has adopted a fairly docile, almost ambivalent stance on media attacks aimed at GPs. Last September it seemed to echo the stance of the Mail and Telegraph, writing to all practices to 'remind' them that patients must be offered face-to-face appointments when they need them.

Four days later surgeries reported that practice staff were being abused by patients following publication of incorrect media stories about a lack of appointments, leading the BMA's GP committee to demand NHSE issues a correction to counter the negative coverage.

Two months after that, in November, former RCGP chair Professor Dame Clare Gerada suggested NHSE shouldn't leave it to GPs to correct misinformation, and should instead set up a rapid rebuttal unit. But in the same month, NHSE primary care medical director Dr Nikki Kanani merely pledged that the organisation "can and will do more" to explain to the public that GP practices are actually open.

In May this year, however, NHSE was again writing to GPs saying they must offer face-to-face appointments, and so the negative stories continued, prompting RCGP chair professor Martin Marshall to write to the Times to challenge the ongoing media criticism.

Only last week one GP told Pulse they felt there was "a deliberate and co-ordinated attack" by the right-wing press, with an underlying agenda patients were starting to believe if left unchallenged. In the same issue Pulse also quoted BMA GP committee chair Dr Richard Vautrey questioning NHSE's position: "NHSE and the Government have a responsibility to the public to challenge this damaging and inaccurate narrative and restore confidence in GPs and all those who work with them."

But the news that NHSE is not planning a public information campaign to explain why GPs are cancelling non-urgent blood tests is hardly reassuring, posing as it does a risk of further abuse from angry patients towards surgery staff.

And NHSE could certainly do more to limit the transfer of work from secondary to primary care – a major concern of doctors which was highlighted in a survey last month by GPonline. Earlier this year the same publication touched on how hospitals were dumping 'endless tasks' on an already overloaded GP network.

**Flagged up in a Telegraph 'exclusive' just as the latest issue of The Lowdown was being put together, this programme seeks to put pressure on almost 1000 GP practices – selected by NHSE – to offer more face-to-face appointments.*

According to the story, the 'access improvement programme' aims to assist these practices – many of which NHSE acknowledges simply have too few staff to provide a safe level of services – by offering them an unspecified amount of additional funding and a 'dedicated adviser' to enable them to see more patients in person.

It's unclear if this story relates to the forthcoming national GP access improvement programme, which has already been announced as an update to the GP contract agreement 2020/21-2023/24.

Martin Shelley

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