The lowdown

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

Plan to tackle NHS queues lacks funding for staff, but favours the private sector

The NHS England 'Delivery Plan' to tackle the growing backlog of waiting list treatment, announced on February 8, is not a plan at all. It lacks sufficient investment and – most important of all – a workforce plan, without which none of the promised improvements will happen.

Indeed as the House of Lords has worked through the committee stage of the Health and Care Bill one topic in which ministers have refused to give any ground at all, for fear of antagonising the Treasury, is on the need for a workforce strategy, as proposed by Jeremy Hunt in the Commons, backed by over 90 professional and other organisations, and by former NHS England boss Simon Stevens and other peers in the Lords.

The new 50-page Delivery Plan also admits from the outset that it doesn't cover mental health, GP services or urgent and emergency care – all of which are facing dire and wors-

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ening problems after a decade of underfunding compounded by the 2-year pandemic.

And while it talks in abstract terms about expanding the NHS workforce and "physical capacity" it does not even discuss ways of reopening the 5,000 or so NHS beds which closed in March 2020 as part of the pandemic preparation – and are still not being used.

They cannot be reopened because the NHS lacks the capital investment required to reorganise space within hospitals and refurbish buildings to allow social distancing and infection control.

Instead NHS England's so-called "plan" is focused on long-term reliance on the "capacity" of the private sector, which means funnelling even more NHS cash into private hospitals and private sector providers, which have already shown themselves during the pandemic to be dreadful value for money.

Institutionalising dependence on private sector

NHS England appears to have learned nothing from the huge, remarkably unproductive spending supposedly block-booking up to 8,000 private hospital beds in 2020. Recent figures have confirmed brought a huge 25% increase in NHS spending on private providers that year, which bolstered their profits – but resulted in the 27 private hospital companies delivering "43% less NHS-funded healthcare than they did in the in the twelve months before the pandemic."

Nonetheless, insofar as there is any plan at all for expanding capacity it is based on a long-term "partnership" with this same private sector – effectively institutionalising NHS dependence on costly and inefficient private sector hospitals and beds.

A 2-page section of the document is focused on "Making effective use of independent sector capacity." It makes it quite clear that the need for the private sector is the lack of adequate NHS capacity, stating from the outset:

"a long-term partnership with our independent sector partners, including charities, will be crucial in providing the capacity we require to deliver timely and high quality care for patients."

It goes on to insist that:

"Systems will include local independent sector capacity as part of elective recovery plans, and will work in partnership with independent sector partners to maximise activity to reduce waiting times sustainably."

Except of course the reliance on private beds and services means that that NHS itself will NOT have sustainable capacity to run as a coherent and comprehensive public service. Despite all the rhetoric about "integration" it will have to rely on profit-seeking private companies.

The most recent 3-month deal signed with private hospitals recognised that the private sector can make more money selling operations to 'self-pay' private patients seeking to skip over long NHS waiting lists than from treating NHS patients at normal NHS tariff prices.

Recipe for deprivation

To use the private sector as additional capacity therefore means the NHS paying over the odds to make it profitable for them – and leaves a lop-sided "partnership" with companies with a very different agenda from the NHS, since they benefit either way from a lengthening NHS waiting list. It also means dividing up the already over-stretched NHS workforce to send teams from major hospitals to deliver operations in small-scale private hospitals miles away.

The other problem with this reliance on private hospitals is that they are not evenly distributed across the country, but concentrated in London, the south east and more prosperous populations. Many more deprived areas which are supposedly to be "levelled up" have no significant access to private hospitals – and will be left out of this aspect of the recovery plan.

Where private hospitals are available as "partners" the Delivery Plan (p22) makes clear that in the long term the NHS would be confined to a role of providing emergency services, medical care and more costly, complex treatments that the private sector has always avoided:

"… joint regular reviews of demand for services and available capacity will support the clinically appropriate transfer of high volume and low complexity conditions, as well as some cancer pathways and diagnostics, to the independent sector. The extra capacity created within the NHS will be used to undertake more complex work such as cardiac, vascular and neurosurgery …."

Meagre promises

But while the NHS is trapped and restricted, the private sector will be free to pick and choose the level of care it sees as most profitable and wishes to provide:

"More complex cases can also be treated in independent sector sites that can deliver this level of treatment."

This long term "partnership" even means that the private sector – which trains no staff, and has always relied on poaching NHS-trained staff – would be drawn in to designing

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NHS now paying for prolonged squeeze on its funding

New figures from the King's Fund, calculating the progress of funding for the NHS and social care since the banking crash of 2007-8 indicate how dramatically the brakes were applied from 2010 when David Cameron's government embarked on a decade of austerity.

But it is widely accepted that to cope with inflation, demographic change (a rising population and an increasing proportion of it in the more costly older age groups), technological change and other cost pressures real spending needs to increase by around 4% each year: and from 1958 to 2010 that was more or less the average (3.9%).

Since the Tory-led coalition took office in 2010, however, the rate of increase has remained consistently below this level, leading to a growing shortfall in funding, and this is set to continue.

Calculating from the King's Fund figures we can see that had the Department of Health and Social Care received an annual increase of 4% from 2010, by 2021-22 – even allowing for inflation – its core budget would have been £180bn – £35bn higher than the actual figure, and just £11bn below the total spending including the £47bn Covid spending.

HCT calculations show that the cumulative gap between pre-2010 average levels of increase and the austerity levels of actual funding reached £202bn this year: and if Rishi Sunak's spending review allocations remain unchanged the gap will widen by another £84bn, to create a near-£300 billion shortfall in the 15 years to 2025.

By contrast when retired banker Sir Derek Wanless examined the long term funding of the NHS for the New Labour government in 2002, he found that by comparison with the European average UK health spending had fallen behind by £267bn – over the previous 25 years.

The current financial squeeze has made all the difference between an NHS that can sustain sufficient beds and staff, keep up with maintenance and invest in precautionary stocks of PPE – and today's conditions of constant crisis.

The SOSNHS call for emergency funding of £20bn appears modest in comparison to the historic shortfall, but the campaign says it is urgently needed to restore NHS performance, increase capacity, reopen unused beds, and raise pay and expand the workforce.

Doctors warned that privateers are destabilising NHS eye surgery

As Sajid Javid announces further private sector involvement in the NHS with the Elective Recovery Plan, there are warnings from ophthalmologists that the safety of NHS patients could be put at risk if the private sector is given any more NHS work.

In the letter, signed by nearly 200 ophthalmologists and sent to NHS England and the Royal College of Ophthalmologists and shared with The Independent, they warn of "the accelerating shift towards independent sector provision of cataract surgery" which is already having a "destabilising impact" on safe ophthalmology provision.

They predict that the wide scale use of private providers will "drain money away from patient care into private pockets as well as poaching staff trained in the NHS." adding that "urgent action" is needed to prevent further work being given to the private sector.

Staff who would normally do extra hours for the NHS are now being offered better paid work doing cataract operations in the private sector, but this means other eye procedures are not being carried out for the NHS and waiting times for these will grow..

Speaking to The Independent, Professor Ben Burton, consultant ophthalmologist and one of the lead signatories of the letter, said: "What's happening is that staff who could be treating preventable but irreversible sight-threatening conditions like glaucoma, macular degeneration, and diabetic retinopathy are instead doing cataract surgery for private providers."

The private sector is already heavily involved with the area of cataract surgery; in November 2021, the Royal College of Ophthalmologists reported that in 2016, 11% of NHS cataract procedures in England were delivered by private companies, but by April 2021 there was almost a 50/50 split, with 46% in the private sector and 54% by NHS trusts and treatment centres.

Cataract surgery is the main training ground for junior doctors, they need to complete at least 350 cataract procedures to be able to then manage more complicated work. The use of the private sector means trainees are finding it harder and harder to access the opportunities.

Long-term investment needed

The NHS is left with the more complex cases, which are less suitable for training. This is making itmore difficult for trainees to successfully complete training and, most importantly, more difficult to develop skilled and experienced surgeons.

At the end of December 2021, the waiting list for elective surgery hit a record 6.1 million, including over 600,000 waiting for eye procedures, according to The Royal College of Ophthalmologists.

The waiting list situation has not been caused entirely by the Covid-19 pandemic, however – waiting lists were high before 2020 due to lack of investment in NHS services and worsening capacity problems.

Professor Burton told the Independent that "what is needed is a long-term sustainable solution rather than a knee-jerk reaction which risks the future of ophthalmology as an NHS service. The long-term solution will be achieved by investing in NHS providers to deliver modern, efficient care, and the private sector only used as a last resort."

Consultancies win pivotal role in NHS recovery plan

Seven companies – Bramble Hub, Deloitte, EY, KPMG, McKinsey & Co, Newton Europe and PwC – are being paid up to £42m for an initial two-month data contract, amid growing concern over the increasing role played by management consultancies within the health service.

Forming part of health secretary Sajid Javid's 'delivery plan' to clear the surgery waiting list backlog – currently around six million patients – the contract is designed to provide "system planning" to support the elective recovery programme.

It will see up to £500,000 being spent across each NHS England region (presumably each integrated care system) up until 31 March, with an option to extend the project by six months and allocate a further £500k per ICS.

News of the contract emerged earlier this month and coincided with a move by NHS Shared Business Services – a joint venture set up by the Department of Health & Social Care and French outsourcing specialist Sopra Steria – to tender for a new contract worth £500m to create a framework for the provision of IT consultancy, advisory and delivery services to the NHS.

It's unclear whether either development is related to the apparent merger of NHS Digital and NHSX within NHSE's recently established 'transformation directorate', but they reflect a continuing willingness to embed consultancies within the health service, despite the private sector's record of poor performance.

Four years ago the independent newsletter The Conversation analysed how more than 100 NHSE hospital trusts – each spending an average of £1.2m a year on consultants – became almost 10 per cent less efficient, and lost around £11,000 for every £100,000 spent.

Last February it followed this up with research showing demand for consultancy advice within NHSE was growing despite evidence that using external advisers actually generated inefficiencies. The Conversation also noted that hospital trusts were rarely hiring consultants to make up for a shortage of in-house managers – in fact the biggest users were those trusts employing relatively more managers.

The Lowdown also offered its own exhaustive analysis of the sector 12 months ago, when it noted that consultancy firms have played a key – and lucrative – role in most of the big re-organisations of the NHS going back at least to 1974. Tellingly, it highlighted a warning from the Financial Times in 2017 which suggested an analogy between consultants and vermin: "The … danger is that consultants become a habit – once they get inside the building, they are hard to eradicate."

Martin Shelley

128 trusts bid for new hospital funding

A staggering 128 trusts – almost two thirds of all trusts in England – have submitted bids to be one of just eight additional promised projects, according to the HSJ. The extra eight projects would bring the total of 'new hospitals' to 48.

Nine out of ten of these trusts will inevitably see their hopes dashed and bids rejected – with no foreseeable prospect under a Tory government of another funding round this decade.

The Lowdown has consistently highlighted the urgent need for new hospitals to replace those built in the 1970s with defective structural planks. Several of these are now either included in larger schemes or submitted separately among the bids that have flooded in as trusts recognise the danger of missing the boat on funding.

One of these, Frimley Health Foundation Trust in Surrey has set out plans for a complete £1.26bn rebuild to transform it into a state-of-the-art net-zero hospital.

Grandiose plans not linked to collapsing buildings include the trusts in Lincolnshire integrated care system, which the HSJ reports have together submitted bids with a total value of £1.2bn.

In London, Imperial College Healthcare has optimistically submitted its Strategic Outline Case for rebuilding St Mary's Hospital in Paddington, including 840 beds, at an estimated "£1.2-1.7 billion net, once receipts from the sale of surplus land are taken into account."

Even some smaller plans are still coming in above £400m, including the £500m plan to replace Stockport's Stepping Hill Hospital, which has a £95m backlog maintenance bill.

The £400m limit is also likely to be a problem for Shropshire's much-delayed 'Future Fit' plan to centralise acute services on a rebuilt Shrewsbury Hospital – for which £312m in capital funding was potentially promised, but the cost of which has now reportedly exceeded £500m.

Centene's investment shake-up could mean NHS u-turn

There was little public attention paid to the decision last year by US health corporation Centene to spend a reported $700 million in cash to buy out the remaining 60% it didn't already own of Circle Health and take complete control.

Circle itself, with increased resources from private equity investors, had in 2020 taken over England's largest private hospitals chain, BMI, with 47 hospitals, 2,400 beds and turnover in excess of £900m. This enabled Circle to pick up the biggest slice of the £2bn-plus NHS contract effectively block-booking almost 8,000 private hospital beds in the first year of the Covid pandemic: Circle's share of that contract, £468m, boosted the company's revenue in 2020 by more than 50%.

So, with just this one major investment, Centene/Operose had leapt into pole position to exploit the turn by the NHS since the Covid pandemic struck to long-term reliance on private hospital beds to compensate for severely restricted numbers of beds available to treat waiting list patients.

It appeared that a major American takeover of health care in England – long feared by many campaigners – was seriously under way, although the lack of any Centene press release boasting of the takeover did seem uncharacteristic for a company seeking expansion of markets and profits.

Instead, just months after forking out big bucks to take over Circle, Centene in December revealed that it was reviewing its strategy, focusing on maximising its profits per share, and, as part of this, considering the possibility of "divesting" itself of all its "non-core" business, including international businesses worth around $2 billion per year out of the corporation's $126bn turnover.

Selling off the international operations would mean disposing of both Circle in the UK and Centene's 90% share of Ribera Salud (which owns and manages the largest private hospital in Spain and has controlling and noncontrolling interests in primary care, outpatient, hospital and diagnostic centres in Spain, Central Europe, and Latin America.)

If it doesn't fit, it doesn't stay...

However Centene's core business remains very much in US insurance, where it covers 26.5 million people, primarily in U.S. government-sponsored programs including Medicaid, Medicare and the Affordable Care Act marketplaces. And its core interest is simple: profit. So now it is looking to slim down its workforce and focus on achieving 2024 earnings per share of between $7.50 and $7.75 – around 50% up on 2021.

Hence its willingness to explore options to "offload its international operations, including a U.K. hospital operator." Sarah London, vice chairman of Centene's board and president of the company's health care enterprises business told Bloomberg:

"We are committed to a comprehensive portfolio review, beginning with non-core assets. Let me say it simply: if it doesn't fit, it doesn't stay."

At the end of the review Centene may, of course, decide to stay and seek ways to maximise what profits it can extract from NHS contracts. But if, as expected, they do decide to pull out, their departure from England would no doubt be linked with selling on their assets to another grasping private operator, who would also need to be fought all the way.

John Lister

Trust opens new surgery facility to avoid outsourcing care to private hospitals

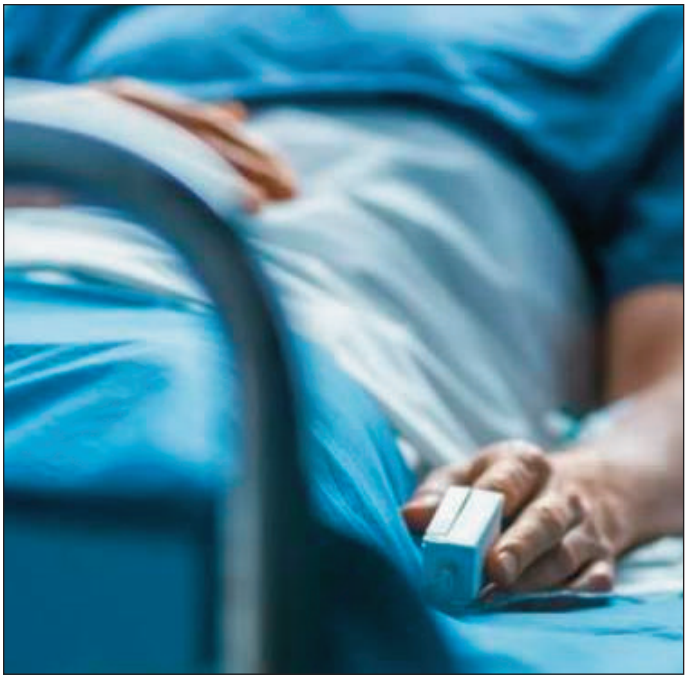
A major hospital trust is seeking to buck the trend of outsourcing healthcare to the independent sector, following the lead of another trust's success in re-establishing elective care during the covid pandemic.

In an effort to reduce its reliance on independent contractors, Maidstone and Tunbridge Wells NHS Trust last month submitted an outline business case to NHS England/Improvement to develop an in-house specialist orthopaedic surgical facility, according to a report in LaingBuissons' Healthcare Markets magazine.

The trust's plan revolves around the creation of a 'barn theatre' model that will include four laminar-flow theatres, along with a 20-bed inpatient ward and a 16-bed day-case unit, all located within its Maidstone Hospital site.

This will enable it to separate elective and emergency work, and also deliver cost savings by cutting the number of orthopaedic patient cases (ie around one in three operations) that are currently outsourced to independent contractors at an annual cost to the trust of £2.8m.

It also suggests that the new set-up would ultimately provide a capacity of 2,500 patients, allowing Maidstone Hospital to take on operations now performed at the trust's Tunbridge Wells site – and potentially at hospitals run by other NHS trusts – as well as those presently undertaken by the private sector.



And the outline business case for the new orthopaedic surgical facility at Maidstone echoes a programme to boost capacity that is already in place at the Croydon Health Services NHS Trust.

The south London trust set up an elective centre for non-covid patients shortly after the first wave of the pandemic receded, in the summer of 2020. It did this by creating a 'hospital within a hospital' – similar in concept to the proposed 'barn theatre' model at Maidstone – based around a protected zone which allowed it to separate elective and emergency care. This allowed the trust to continue with clinically prioritised elective work during the second wave of the pandemic.

The project triggered the creation of an emergency surgical centre, and led to the redesigning of the trust's day surgery complex to provide dedicated theatres for non-elective work. It also saw the transformation of the Purley War Memorial Community Hospital into a high-volume, low-acuity elective centre.

Mutual aid benefits

As well as benefiting patients within the Croydon area, the project has enabled the trust to become a net provider of mutual aid to other trusts, last summer taking up to 1,600 patients from other trusts within the South West London ICS for high-volume, low-acuity procedures including gynaecology, ENT, general surgery and urology.

Despite this evident success, however, the government seems determined to maintain its blinkered approach to solving capacity issues in the NHS. Consider the health service's new 'delivery plan', which ignores the issue of reopening the 5,000 NHS beds that closed in March 2020 as part of the pandemic preparation. And consider health secretary Sajid Javid decision recently to force through another 'surge capacity' deal with independent providers – a move described by NHSE ceo Amanda Pritchard as being "on a per bed basis… significantly more expensive than the equivalent costs of an NHS site".

But Croydon's experience shows that bringing in the independent sector to clear elective surgery waiting lists – now approaching six million patients nationally – doesn't have to be the default option, and hopefully Maidstone will get the chance to prove that point soon too.

Martin Shelley

Overwhelming inequalities affect minority ethnic people in the NHS

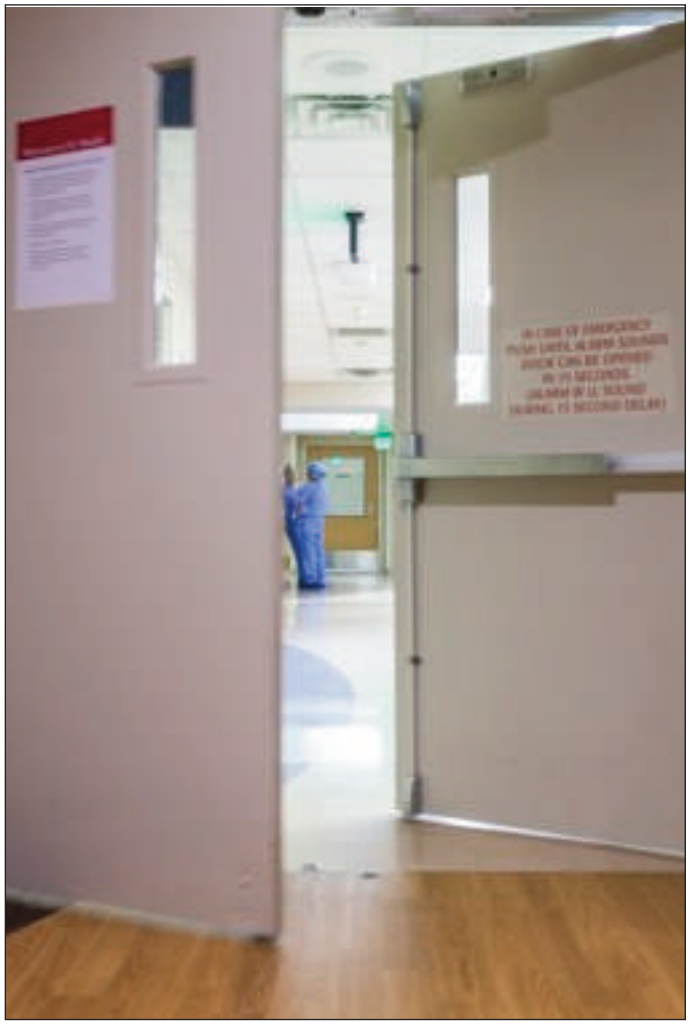
This week saw the publication of a damning review by the NHS Race & Health Observatory which shows that urgent action is needed to tackle "overwhelming" minority ethnic health inequalities in the NHS.

Doctors working in the NHS have, however, called for more action rather than reports. Responding to the report Dr Rajesh Mohan, Presidential Lead for Race and Equality at the Royal College of Psychiatrists, said: "The Race and Health Observatory's findings are damning. It's clear that the government and the NHS must do more if it's to stop the healthcare system from failing ethnic minority people."

He called for "warm words to end and for the government to act" including strengthening the Health and Care Bill to ensure data and monitoring systems are in place that enable the NHS to identify and address discrepancies in access, experience and outcomes for all minority groups plus a "systematic shift in culture and practice, including designing and commissioning services collaboratively with people from ethnic minority backgrounds."

The review revealed vast inequalities across a range of health services that mean the health of Black, Asian and minority ethnic people across England have been "negatively impacted" for years.

The review looked at mental healthcare, maternal and neonatal healthcare, digital access, genetic testing, and at the workforce in the NHS.



Problem worst in mental healthcare

Ethnic inequalities were found in each area, but some of the largest inequalities were found in mental healthcare. The review of academic research, spanning a 10-year period, found that ethnic minority groups experienced distinct inequalities in mental health support provision, and in gaining access to mental health 'talking therapies'.

The review found that there was a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare, which produced a barrier to seeking help.

Once help was sought, GPs were less likely to refer ethnic minority patients to the Improving Access to Psychological Therapies (IAPT) programme, compared to White patients and overall, ethnic minority groups were less likely to refer themselves to IAPT. There was also evidence for inequalities in the receipt of cognitive behavioural therapy (CBT) with ethnic minority people with psychosis less likely to be referred for CBT, and less likely to attend as many sessions as their White counterparts.

There was strong evidence of clear, very large and persisting ethnic inequalities in compulsory admission to psychiatric wards, particularly affecting Black groups, but also Mixed Black & White groups and South Asian groups. There was also evidence of harsher treatment for Black groups in inpatient wards, for example they were more likely to be restrained in the prone position or put into seclusion.

Ethnic inequalities in mental healthcare for adult populations are now being reproduced in younger populations, according to

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Empty words and vague ideas on integration

The new White Paper on integration of health and social care Joining up care for people, places and populations has an early warning of how vacuous much of its content will be: pictures of smugly grinning Sajid Javid and Michael Gove.

The document instantly fails the Lowdown's quick test of seriousness: it has just four instances of the '£' sign in 70 pages, confirming that it does not discuss finances – and of course without financial resources its various vague ideas and promises are simply empty words.

The Foreword gives more grounds for concern, in fostering the illusion that – even if they were available – "universal access to high-quality treatment and support in all parts of the country" would be sufficient to bridge the growing gap in healthy life expectancy between rich and poor areas.

The social and economic inequalities, which have been systematically widened since 2010, and more rapidly widened since 2019 despite the rhetorical commitment to "levelling up," are such a fundamental social determinant of health that even the most lavishly funded NHS and social care would not compensate for them, let alone the brutally under-funded services that struggle through after a decade and more of real-terms cuts.

The Foreword also highlights proposals that are potentially controversial with NHS and local government, and with health and social care staff.

NHS Providers' response highlights the lack of either a workforce plan, or adequate funding in health and social care:

"While the aspirations for a more integrated health and care workforce is welcome, the paper fails to acknowledge the scale of staff shortages in the NHS and social care sector and the national action required to tackle them. …

"… Pooling NHS and social care budgets is no substitute for funding both systems appropriately and placing social care services on a sustainable footing."

Pooling of staff unlikely to work

It is equally unlikely that seeking effectively to pool staff between the very different, under-staffed health and social care systems can work, despite the White Paper seeking to "create a more agile workforce with care workers and nurses easily moving between roles in the NHS and the care sector."

While many staff working for low-wage, exploitative private companies delivering social care may well aspire to the superior pay, terms and conditions of their equivalents in the NHS, there are few, if any, grounds to believe NHS staff might happily swap places in the other direction.

NHS Providers notes the disparity in funding of the two systems, stating: "We remain concerned that this approach [pooling budgets] would risk the NHS budget becoming exposed to severe and well-established funding pressures in social care."

With no significant increased revenue funding or investment on offer to either health or social care the fantasy world of Tory ministers seems even more ridiculous as they aspire to a completelyunattainable notion of "integration":

"Successful integration is the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole."

A starker contrast with the actual dysfunctional, fragmented, privatised and cash-starved services is difficult to imagine. And, when it's not so much lack of information as lack of hard cash that is blocking progress, the White Paper's misplaced belief in the magical powers of data is also incongruous:

"Unlocking the power of data across local authorities and the NHS will provide place-based leaders with the information to put in place new and innovative services to tackle the problems facing their communities."

Once more this is at complete variance from the likely outcome of half-hearted investment in unproven and disconnected whiz-kiddery while core services lack staff and resources. The White Paper is a wish list rather than a vision – while staff and service users on the ground face the harsh reality.

John Lister

PUTTING THE DAFT INTO DRAFT PROPOSALS

NHS Providers has warned of the additional complications of requiring a single person to be "accountable for delivery of a shared plan at local ['place'] level," warning:

"Introducing a single person accountable for health and care at place, and expecting greater pooling of NHS and social care funding – without altering the underlying financial flows, infrastructure and accountabilities – will introduce further risk into an already fragile, and under-funded, system."

NHS Providers also warns of the growing complexity of the system proposed by the Health and Care Bill, which would establish 42 Integrated Care Boards (ICBs), and larger numbers of Integrated care Partnerships (ICPs), answerable to NHS England/Improvement (NHSE/I):

"It is very striking how many trust leaders are currently saying that accountability between trust boards, ICBs, ICPs and NHSE/I regions feels very opaque and potentially confused. …

"… In particular, it is hard to see how a single leader can be accountable for the delivery of shared outcomes across the NHS and local authorities given existing statutory accountabilities for both systems will remain in place. This will lead to much greater complexity and high levels of risk being carried across all the different players in a system."

One example of this is in Norfolk and Waveney ICS, wher the chair of one of the acute trusts has broken the usual polite silence by declaring that the proposed structure of the ICS, involving no less than twelve separate bodies, is "absolutely daft," and she was "struggling to navigate what each group does". A look at the document from the "interim partnership board" confirms her view, explaining the complex network of bodies beneath the ICB:

"We are creating five local health and care alliances ('Alliances') based on our current health localities. … They will be accountable to our Integrated Care Board ('ICB').

"We are also creating 7 local health and wellbeing partnerships ('Partnerships') alongside our Integrated Care Partnership ('ICP') to progress our work on addressing the wider determinants of health, improving upstream prevention of avoidable crises, reducing health inequalities, and aligning NHS and local government services and commissioning. These partnerships will be based on district footprints."

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"a joint approach on workforce…"

Meanwhile the promises in the Delivery Plan, even though they are based on highly optimistic and questionable assumptions (not least the ability with no significant investment in workforce to deliver "30% more elective activity by 2024/25 than before the pandemic") are meagre.

Cancer patients are promised that numbers waiting more than 62 days from an urgent referral will be reduced "to pre-pandemic levels by March 2023" (by which time many will have died waiting). But even before the pandemic the 62-day target to start cancer treatment had only been met once in five years, and more than one in five cancer patients waited more than two months for their first treatment.

Waits of over a year for non-cancer treatment won't be eliminated until 2025– after the next election. Numbers waiting are expected to rise – perhaps as high as 9 million – until 2024.

This plan will be welcomed by private sector hospitals and providers: but it offers no real hope to patients or stressed out NHS staff, and threatens to consolidate the biggest-ever expansion of spending on private providers as a permanent feature of the NHS going forward.

It underlines the need for the £20 billion extra emergency funding demanded by SOSNHS, the campaign backed by health unions and campaign groups, which is staging a Day of Action on February 26 and a rally in central London on the eve of the Spring Budget..

John Lister

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evidence found by the review. Parents reported their children facing the same barriers to accessing services as reported for adult mental health services.

One study in the review showed that Black children were 10 times more likely to be referred to Child and Adolescent Mental Health Services (CAMHS) via social services rather than their GP service, in comparison to White British children.

A major barrier to the work carried out for the review was the lack of national datasets with high quality ethnic monitoring data that allowed for robust analysis to investigate ethnic inequalities. The authors noted that many recent reports from NHS Digital did not report differences in referral rates by ethnic group.

In maternal healthcare, the review found evidence of negative interactions, stereotyping, disrespect, discrimination and cultural insensitivity, leading to some ethnic minority women feeling 'othered', unwelcome, and poorly cared-for.

The impact of racism on careers and professional development was also explored in the review, and there was evidence of an ethnic pay gap affecting Black, Asian, Mixed and Other groups, and to a lesser extent, Chinese staff.

The review was carried out by teams at the University of Manchester, working in conjunction with the University of Sheffield and the University of Sussex. The academic team undertook a comprehensive stock-take of available UK research, screening over 13,000 research papers, identifying 178 studies that were included in the final review.

Sylvia Davidson

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