The lowdown

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

# What will the next Prime Minister do for the NHS?

**The health service barely rated a mention in the recent C4 and ITV leadership debates, with each candidate carefully skirting around any mention of the NHS or social care. No bragging this time about the 40 new hospitals, the 6,000 extra GPs or the 50,000 new nurses that have long been a part of Johnson-era Tory messaging.**

And given the electorate the candidates were targeting – currently just their own party's MPs, but soon set to include the wider Conservative Party membership (older, more affluent and more middle class than the rest of the UK population) – it's unlikely they'll be any more forthcoming on such a politically sensitive topic. But during the C4 and ITV debates what actions, if any, have the remaining four candidates to be the next prime minister actually committed to on

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health-related matters, and how have they voted on such issues in the past? Let's take a look...

**Kemi Badenoch**

*Badenoch did her best to stick to the party line during the debates, but admitted the NHS was in crisis, admitting that she struggled to find a dentist in recent months to fix a chipped tooth.*

*She didn't directly address her plans for health and social care in her campaign launch speech in the days leading up to the debates, but gave a hint earlier this year when she dismissed evidence of a care funding crisis for councils, telling a Commons committee, "We think the funding is at the right amount."*

*Badenoch's parliamentary voting record shows she has consistently voted for reducing central government funding of local government, and that she has never rebelled against her party in the current parliament.*

**Liz Truss**

*The foreign secretary made no concrete policy announcements during the debates, save for repeating her pledge to scrap the proposed health and social care National Insurance levy, a tax designed to improve social care and to help the NHS deal with the backlog of patients waiting for treatment following the pandemic.*

*Truss has notably claimed that the NHS "remains off the table" in any post-Brexit trade deals, but her voting record suggests a more questionable approach to healthcare: in the House of Commons she has consistently voted against paying higher benefits over longer periods for those unable to work due to illness or disability, and has almost always voted against restricting the provision of services to private patients by the NHS. Truss has never rebelled against her party in the current parliament.*

**Penny Mordaunt**

*The minister of state for trade policy's leadership campaign launch video had to be edited a couple of times – most notably for mistakenly featuring a scene from a Spanish hospital instead of an NHS site – but Mordaunt's campaign did include at least one policy innovation, albeit one unlikely to have an immediate impact: the establishment of a taskforce to address the 'paralysis' in accessing NHS services.*

*Quite how the recommendations of that taskforce would be paid for is unclear, though, because – like most of the other candidates in the debate – she is likely to abandon the health and social care NI levy if elected prime minister, according to the Sun.*

*Other policy innovations featuring in the Portsmouth North MP's campaign are equally less than impressive, not least her slightly inane claim that medical innovations were rarely used in the NHS – a claim which has sparked ridicule in the medical profession.*

*Centralised lists of GPs and dentists – another Mordaunt idea, and one she promoted during the TV debates – so that patients having difficulty getting a local appointment can look further afield, sounds sensible but fails to acknowledge a supply crisis that is national in scale.*

*More radically, perhaps, Mordaunt could have pushed the practice of homeopathy, which she has advocated for more than a decade. Although it didn't feature during her debate presentations this month, as long ago as 2010 the MP supported an early day motion in the House of Commons criticising the BMA for voting to withdraw NHS support for homeopathy.*

*On the question of privatisation, Mordaunt seems to be on firmer ground ethically, telling campaigners in Portsmouth last September that the principles of the NHS "would not be up for grabs". More worrying, perhaps, is her opposition to mandatory covid jabs for health and social care workers,*

*and the black marks on her recent Commons voting record.*

*She has voted against smoking bans, always voted to reduce central government funding of local government, and consistently voted against restricting the provision of services to private patients by the NHS.*

**Rishi Sunak**

*The chancellor made no specific new commitments regarding health and social care during the two debates, but was of course keen to stress that the country could trust him to look after the NHS – citing his determination to stick with the health and social care NI levy (which he introduced) and to resist the politically expedient option of cutting taxes, at least in the short term.*

*But despite his obvious pride in his parents' careers (his father was a GP and his mother was a pharmacist) and his promise that as prime minister he would "focus a lot on improving the outcome of public services", Sunak's voting record betrays a similar cynicism to that of his rivals in the debates.*

*He has consistently voted for reducing central government funding of local government, consistently voted against paying higher benefits over longer periods for those unable to work due to illness or disability, and consistently voted for a reduction in spending on welfare benefits.*

The defining message from the TV debates – bar Rishi Sunak's lone stand – was that more tax cuts were needed, disregarding their potential impact on the NHS, and it was sobering to note that none of the participants in the C4 debate even mentioned the health service in their closing statements.

Before the debates, the 11 candidates initially involved collectively announced £330bn in tax cuts, more than the entire NHS budget, according to the Labour Party. As some commentators have suggested, these cuts must either be met by increased borrowing – unlikely to happen under a Sunak administration – or be matched by reductions in spending on public services.

But with nine out of ten NHS leaders saying their efforts to reduce waiting lists are already being hindered by a lack of investment in buildings, a workforce in crisis and a failure to ensure that social care is appropriately supported, the remaining leadership candidates must surely adopt a more realistic approach to the nation's health.

As NHS Confederation chief executive Matthew Taylor said after the second TV debate, "What the NHS and the public really need from politicians right now is a realism reset and a promise to level honestly with them.

"We need a proper acknowledgement of where the last 10 years of austerity have left the NHS… That honesty means [acknowledging] the crumbling buildings and ill-equipped and outdated estate, 105,000 staff vacancies at the last count, and a social care system in desperate need of repair and very far from being fixed."

***Martin Shelley***

# Warnings for coming winter as NHS capacity reduced


**As a new strain of Covid-19 triggers yet another surge of hospital admissions, tying up more front line resources, emergency consultants are warning of a grim winter ahead for the NHS.**

The most recent NHS England figures show almost 9,000 (8,928) hospital beds occupied by Covid patients on June 30, a sharp increase from the recent lowest level of 3,800 beds at the beginning of June.

And while the success of the vaccination programme means that a much smaller proportion of Covid patients are needing ITU treatment, this increased number of general and acute beds that are not available to treat the normal emergency or elective case-load has run alongside a significant reduction in numbers of acute beds that are occupied.

Bed availability and occupancy figures from Quarter 4 of 2021-22 show there were 3,385 fewer beds occupied than in the equivalent period just before the pandemic (2018-19). So the combination of Covid cases and reduced capacity mean that over 12,000 (almost one in eight) acute beds in England are unavailable for normal activity, and the Covid beds still require nursing cover.

This has led to a drastic drop in performance of emergency services and a continued increase in the waiting list to more than 6.5m.

With this shortage of beds coupled with chronic staff shortages affecting many trusts, and a renewed increase in Covid infections driving up sickness absence, it's hardly surprising that NHS trusts are unable even to reach pre-pandemic levels of activity, let alone reach NHS England targets to increase beyond them by 10% this year (in the hopes of securing extra funding) in an effort to cut growing waiting lists. It now seems that these targets may have to be abandoned.

The HSJ has published internal data to show that raw elective activity levels from the start of April to mid-June have averaged around 88 per cent of the level in the same period during 2019-20. It quotes Rory Deighton, acute lead for the NHS Confederation, who said:

"We need to be clear that the capacity gap remains stubbornly high…The sooner the government recognises the relationship between elective recovery, social care capacity, and capital investment, the sooner healthcare leaders can start to make further progress on waiting lists."

The link between reduced capacity and falling performance is especially clear when it comes to A&E and emergency admissions.

NHS England statistics show that although numbers attending A&E have increased since the end of the lockdown and from the lowest levels at the peak of the pandemic, they are in general still below the pre-pandemic level. However delays of over 4 hours in finding beds for emergency admissions have increased, and 12-hour plus delays in finding beds for emergency admissions have increased massively.

In the July-September quarter last year A&E attendances of the most serious Type 1 patients were fractionally (2%) up on the same quarter in 2019, although total attendances were slightly

down: but there was a 61% increase in numbers of patients stuck on trolleys waiting over 4 hours for a bed, and a near 8-fold increase in numbers waiting over 12 hours.

In the October-December quarter of 2021 there were 3% FEWER Type 1 patients and 6.5% fewer overall attendances than in the same quarter of 2019, but a 35% increase in 4 hour trolley waits and more than a 7-fold increase in 12 hour waits.

And in January-March this year there was another small drop in A&E attendances compared with the same period in 2019, but a 74% increase in 4-hour trolley waits and a staggering 3,755% increase in 12-hour plus trolley waits.

**Discharging still a major issue**

The reason for this is that the hospitals are increasingly filled with patients who should be discharged to social care, community services or home with appropriate support, but can't be because the necessary services out of hospital are not in place.

As we reported last month, the new financial year has also seen many, if not all trusts and local commissioners cut the funding that was put in place during the pandemic to help speed the process of discharge and reduce the numbers of patients in hospital for over 21 days.

If patients who should be cared for elsewhere can't be discharged, this further limits the capacity to treat emergencies and elective patients, and results in queues of ambulances that have been forming with grim regularity outside hospitals across England.

One ambulance crew in Portsmouth recently tweeted a photo of 21 ambulances ahead of them waiting to hand patients over as they arrived with an emergency patient.

Now the Royal College of Emergency Medicine (RCEM) is warning that this situation augurs poorly for the coming winter. They have published a snapshot survey of 60 Emergency Department (ED) leads across the UK (51 of them in England) which found:

nearly 80% of respondents reported that their hospital had ambulances waiting outside to offload patients every day last week

seven out of 10 said that their hospital had had to provide care for patients in corridors every day last week

over one third reported that their longest patient wait in the emergency department in the last week was over two days

Commenting on the findings, President of The Royal College of Emergency Medicine, Dr Katherine Henderson said:

"This is the height of summer and yet we are seeing a state of affairs that we'd be dismayed by even in the depths of winter. One in 10 clinical leads reported that some patients are waiting for more than three days for admission. Corridors are full. Ambulances stuck. Patients suffering. This is not what a recovery is supposed to look like."

The RCEM has coupled this with a hard hitting critique of NHS England's 10 point Action Plan for Urgent and Emergency Care Recovery, published last September.

Dr Henderson sums it up: "There has been little action on new metrics. Little increase in same day emergency care provision. Little help for community health teams. Little funding. No timescales. No transparency. No accountability. No improvement. The 'plan' has comprehensively failed so far."

The RCEM notes the particular failure to improve flow through hospitals, without which there can be no improvement in A&E performance:

"The plan failed to address and improve patient flow through hospitals. This winter, average bed occupancy stood at 91.9%, six percentage points higher than the year before. This winter also saw the highest numbers of long stay patients in hospital for seven, 14 and 21 days or more since winter 2017/18. There was a substantial increase in ambulance handover delays. By week 13 of the Winter Sit Reps, delays as a proportion of arrivals were 2.7 times higher than the previous year."

**Corridor care**

The RCEM is also scathing on the huge increase in "corridor care": "Despite the plan outlining an expectation of no corridor care, in March 2022, NHS England reported the largest monthly increase on record for the number of 12-hour waits from decision to admit, with an increase of more than 6,000 from the 16,404 recorded in the previous month. … Any future UEC strategy must tackle the root causes of crowding by eliminating exit block. High numbers of covid associated admissions is adding to staffing and capacity pressures."

With the now former Secretary of State having set his face against any increase in NHS resources, despite all this evidence that existing capacity is completely inadequate, and little hope that the new incumbent will be any more responsive to the needs of patients and staff, Dr Henderson concludes:

"As we look ahead to winter, there are no simple solutions to tackle a situation that has deteriorated significantly over the past decade. One thing the government should do is find ways to increase social care staffing as a matter of urgency, as this is where a lot of our problems lie. This will help us to unblock hospitals and get patients moving through the system again."

**Seeing the light on bed numbers?**

After decades of efforts by NHS management to cut back numbers of front line beds, there is a hint that NHS England chief executive Amanda Pritchard may finally have seen the light, and recognised that the cuts have gone far too far.

In a speech to the NHS ConfedExpo conference in Liverpool

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last month, she said that emergency care was facing "winter pressures in the middle of summer."

She admitted that issues facing social care are not likely to be resolved before winter, but also raised concerns about any further reduction in the number of hospital beds, saying: "The NHS has long had one of the lowest bed bases among comparable health systems, and in many respects this reflects on our efficiency and our drives to deliver better care in the community… [but] we have passed the point at which that efficiency actually becomes inefficient."

**Private sector no help – official**

The Lowdown has frequently argued that the private hospital sector, which does not offer any emergency services, and is focused on simple, swift and low risk elective care, is no solution to the NHS problems with delays in emergency admissions and many of more complex elective treatments.

This has been borne out by a recent HSJ report which has found that in eight of the 10 largest specialties by volume the amount of NHS elective work carried out by the private sector in early 2022 was lower than in a comparable period before the pandemic.

This is despite the framework agreement, worth up to £10bn over 4 years, which was signed by NHS England with the private hospitals in order to make it easier for NHS trusts to make use of private beds.

The new HSJ research follows on a similar analysis in December which suggested that despite the rhetoric the NHS sent less elective work to private sector providers in almost all specialties during the first six months of 2021-22 compared to pre-pandemic levels.

The two exceptions, in December and in June were in ophthalmology and dermatology, both of which recorded more activity than pre-pandemic.

The reductions in private caseload identified by the HSJ range from just 2% in oral surgery, 14% in General Surgery, and 16% in Orthopaedics, to more than 20% in Rheumatology, Gynaecology and Urology, 39% in ENT and 47% in Gastroentrology.

The HSJ report appears to struggle to explain the failure of trusts and commissioners to implement a policy that would siphon cash from the NHS and require secondment of NHS staff to make full use of inherently limited private hospitals, whose average size is just 40 beds and many of which are some distance from major NHS hospitals.

The staffing issue does seem to be one practical obstacle: since both the private sector and the NHS can only recruit from the same limited pool of staff, most of whom (other than overseas staff) have been trained by the NHS at taxpayers' expense, any expansion of NHS work in private beds is likely to lead to further problems staffing NHS wards and operating theatres.

For those of us concerned at the potential increased, long term and costly NHS dependence on the private sector, with a consequent negative impact on equalities and access to NHS care, the failure to transfer the expected amount of work is a positive thing.

But of course evidence that even in the toughest times the NHS does not view the private hospitals as useful "partners" has dismayed the Independent Healthcare Provider Network lobby group. And some of us are quite pleased to see that as well.

***John Lister***

# NAO investigates as 'new hospitals' promise now certain to be broken

**Amid the turmoil of the change of health secretary and chancellor there is another major question mark over the credibility of another major Tory policy commitment that was key to Boris Johnson's election victory in 2019 – the promise of the "biggest, boldest, hospital building programme in a generation".**

The National Audit Office is to review the election pledge to build 40 new hospitals as NHS bosses warn for the first time that none of them will be built before the next election in 2024.

The NAO review will investigate the value for money of the new hospitals scheme, and will also look into how many of the 40 are in fact new hospitals rather than extensions or refurbishments. Although they will not report until next year, the findings will certainly prove uncomfortable for whoever is in Downing Street when they are published.

For readers who have not followed this sorry saga of rhetoric disconnected from resources, which has now dragged on almost three years, here is an update.

The Lowdown has been warning since the autumn of 2019 that Boris Johnson's populist promise soon after taking over as Tory leader to build "40 new hospitals" was a con. Labour's shadow health secretary Jon Ashworth promptly branded them the 'fake forty.

The government's claims have been rewritten and spun numerous times since then to avoid the embarrassing truth that there was never anywhere near enough money in the pot to build even the six initial schemes that were in theory allocated funding totalling £2.7bn.

### Misleadingly presented

From the outset the financing of the new builds and rebuilds was questionable and misleadingly presented. In August 2019 ministers also promised £1.8 billion in capital for smaller projects to "upgrade outdated facilities and equipment" including upgrades in 20 hospitals. But it was swiftly revealed that £1bn of the £1.8bn of it was not new money at all, but cash already in Trust accounts, which they had been forbidden to spend by NHS England, in a 20% cutback announced the previous month.

NHS Providers, the body representing trusts, was calling for sustained increases in capital funding arguing that:

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

Following the announcement that new hospitals were to be funded, NHS Providers responded:

"It's not just these six hospitals who have crumbling, outdated, infrastructure – community and mental health trusts, ambulance services and other hospitals across the country have equally pressing needs. We also need increased capital spending to support changes in the way care is delivered, including in IT and digital, to deliver the new NHS long term plan."

Nonetheless the promise of 40 new hospitals was prominent in the 2019 Conservative manifesto, as Boris Johnson successfully used it to convince enough pro-Brexit Labour voters in the so-called 'Red Wall' seats of the midlands and the north that they could trust the Tories with the NHS.

Three years later, with the backlog bill for maintenance increased by more than 50% from £6bn to over £9bn, even the normally timid NHS Confederation is now warning that not one of

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Boris Johnson's promised "new hospitals" will be built before the election, "And in fact, no work has even started in most cases."

Desperate Downing Street spin doctors have again tried to weasel their way round the issue by claiming "The funding for the initial schemes has been approved and by 2024, six hospitals will be completed with a further 30 under way."

**Unrealistic timescale**

The problem with this is that it's quite clear that 30 schemes will NOT be under way by 2024, and even if six projects are completed by then, they will not be the new hospitals that were promised by Johnson. The £2.7bn promised was then, and is now, quite obviously nowhere near enough to build all of the schemes that were misleadingly portrayed as ready to go, let alone any more.

The initial funding for the six schemes that was approved back in 2020 has not been increased, and unless there is an abrupt U-turn by the new Chancellor Nadhim Zahawi, ministers have been insisting that there will be no further increase in capital or revenue funding for the NHS.

So it's already certain that none of the six hospital projects supposedly given the immediate go-ahead in 2019 will be completed by 2024 – and increasingly unlikely that many of these, if any, will have even started.

The initial six, which were expected to share the £2.7bn initial capital allocation for new builds and be delivered by 2025, were named as Epsom & St Helier trust in SW London, Whipps Cross Hospital, in NE London (subsumed into the morass of the Barts Health Trust); Leeds Teaching Hospitals Trust plans to build new 'hospitals' for adults and children on the Leeds General Infirmary site; West Hertfordshire Hospitals Trust's plan for a new hospital, (controversially in Watford, the least accessible site); a new replacement for Princess Alexandra Hospital in Harlow; and a reconfiguration of services by University Hospitals of Leicester, with controversial plans to reduce from three sites: to two.

Projected costs had soared even before the latest leap in inflation (the West Hertfordshire project was initially allocated £400m in 2019, well short of the £750m estimated actual cost of a new hospital in the Trust's Strategic Outline Case: but the most recent estimate of the cost is now £1.2 billion – three times the initial allocation and over 40% of the total capital set aside for all of the first six schemes).

**Poor capital allocation**

There have been local delays to all six schemes at local level – but the overwhelming problem has been the inadequate allocation of capital, and more recently insufficient funding even to pay for the preparation of plans and business cases, compounded by rows between ministers over the relative priority of NHS projects.

All this has been compounded by the ineptitude of the New Hospitals Programme (NHP), set up in 2020, which employs an astonishing 170 people but has yet to deliver a single functioning project, or even make an honest statement about the desperate lack of resources that makes their task impossible.

The NHP was set up in October 2020, when the new hospitals story was completely rewritten by Department of Health and Social Care spin doctors. They re-announced the £3.7bn allocation of capital to cover a variety of new hospitals and various smaller capital projects – and declared that the task was now to deliver "40 hospitals, with a further 8 schemes invited to bid for future funding to deliver 48 hospitals by 2030."

This was coupled with a substantially changed list of projects, 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; Cumberland Cancer Hospital; Royal Liverpool Hospital; 3Ts Hospital, Brighton. All of these pre-date Johnson's 2019 pledge. The hugely-delayed, PFI-funded Royal Liverpool Hospital and Midland Metropolitan Hospital projects were signed off under David Cameron, halted by the collapse of Carillion in January 2018 – and are still not complete. While Liverpool is now expected to open this year, the Midland Metropolitan has again been delayed and is not expected to open until spring 2024, six years late.

Four more previously omitted schemes were listed as "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.

In addition, the six supposedly 'funded' initial schemes listed above were also included, with two more schemes, rebuilding Hillingdon Hospital (serving Boris Johnson's constituency) and North Manchester General Hospital, were added to the priority list – to make eight 'pathfinder' schemes. But no more money was added to the money in the pot to finance this first round of new projects up to 2025.

These 16 were lumped together with schemes for five small community hospitals in Dorset, a newly announced rebuild of the small Shotley Bridge hospital in Durham, and various other projects, many of them refurbishment or extensions, to make up a total of 40 'new hospitals'.

The same press release also announced for the first time that there would be a "competition for 8 further hospitals including new mental health hospitals." This was eventually launched in the summer of 2021 and led to an avalanche of applications from desperate trusts facing massive backlog bills for maintenance, several of which are even facing the potential collapse of busy hospital buildings.

Among the hospitals facing this threat 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 esti7¶mates that it would take 15 years and cost £555m to replace all of the crumbling concrete planks, while West Suffolk Hospital (the only hospital of this type on the list of new hospital projects) reported a monster backlog of £634.9m.

In Kings Lynn, where the Queen Elizabeth Hospital is now held up by a staggering 1,500 props, the estimated cost of repairing the roof is £500m.

But even the danger of hospitals collapsing has not brought any progress. In early July 2021 the leader of the New Hospital Programme, Natalie Forrest, admitted that "the 'brakes had come on'" for some of the pathfinder projects, and claimed there were concerns over the capacity of the construction industry to complete so many projects by 2030. She also admitted that several of the pathfinder schemes were unlikely to start before 2023-24.

However, Ms Forrest avoided any mention of other key issues: the need to alter and expand some schemes to allow extra space because of Covid, and new carbon neutral requirements. These mean more excess costs above the allocated levels of funding, and further question the affordability and viability of the pathfinder schemes – and many of the others in the queue for funding.

The funding issue came to the fore three weeks later, at the end of last July, when the New Hospital Programme team wrote to all eight "pathfinder" trusts calling for them to draw up cheaper plans, asking them to submit three sets of plans for evaluation – including an option costing no more than £400m, along with their preferred scheme, and options for building the project in phases.

**The new 'new'**

The prospect of a price cap of £400m would be a major problem: all of the five schemes that had published costed plans were already over £400m, and the others are likely to be at least as costly. Cutting back these hospitals to comply with the £400m cap could mean disastrous reductions in beds and services.

In August 2021 the HSJ revealed the leaked content of a new government PR "Playbook" with a hugely contentious interpretation of what constituted a "new hospital".

The Playbook's bizarre concept of "new hospitals" got off to a shaky start as then Health and Social Care Secretary Sajid Javid was widely ridiculed on social media and in some mainstream news coverage for his claim to be opening one of the "48 new

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hospitals" – when he was in fact opening only a new cancer centre on the Cumberland Infirmary site in Carlisle. The building had been commissioned years before Johnson made his promise.

The Playbook also re-divided the various schemes into five "phases":

*– Phase 1: "In-flight" schemes – the four that were under construction or shortly to start construction and were currently anticipated to complete construction between 2021 and 2025.*

*– Phase 2: "Agile" schemes – were 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 were "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".*

**Damaging public trust**

Of the list of 32 projects which the Playbook insisted had to 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 even embarrassed hardened comms professionals. It was immediately 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."

In January this year the HSJ revealed that a staggering 128 trusts – almost two thirds of all trusts in England – had submitted bids to be one of the "next eight" schemes, to bring the total of new hospitals to 48.

However a number of these projects were admitted to cost in excess of £1bn, with many more in excess of £500m. Without a massive expansion of the capital funding, these stand no chance of being adopted.

In any case more than nine out of ten of all the submitted proposals will simply be rejected, although the deadline for announcing which schemes have been selected (and therefore which have been dumped in the bin for the indefinite future, shattering any hopes of repairing and improving services in many areas that have been offered completely false hope) has now been postponed to the end of the year

The Infrastructure and Projects Authority (IPA) has given the New Hospitals Programme an "amber/red" ranking, meaning its delivery "is in doubt with major risks or issues apparent in a number of key areas".

**A broken pledge**

In an attempt to show some results despite limited resources, the NHP has shifted ground, sidelining the initial 6 'pathfinder' projects that were supposedly ready to roll in 2019, and prioritising ten smaller-scale schemes described as 'agile', hoping for "delivery between 2024-26 despite initially being scheduled for 2025-2030." The larger rebuilds are now slated for the "latter half of this decade."

Meanwhile any hope of even starting the 'pathfinder' projects has been further diminished by cuts in funding for the trusts concerned to draw up plans and business cases. In one way this makes sense, since any plans drawn up that can't be funded are simply a waste of time and money; but of course nobody is admitting this to be the case.

The HSJ reports that the eight trusts are due to receive just £1m each towards this preparatory work in 2022-23, far short of what each trust needs. West Hertfordshire Hospitals Trust said in May that as a result it has had to "stand down" its external advisers, leaving the Trust unable even to complete the outline business case, an essential first step to getting the plan endorsed and releasing the necessary funding for the project.

Whether the new Chancellor, under pressure from Johnson to cut taxes, will at the same time decide to pump extra capital into the NHS, and whether the new Health and Social Care Secretary – former Treasury minister and Johnson's chief of staff Steve Barclay, whose first statement claimed "This government is investing more than ever before in our NHS and care services" – will even ask for more money, remains to be seen.

Some already see Barclay is an unlikely champion of more investment: HSJ deputy Editor Dave West comments on Twitter: "Officials say experience with Barclay means they are expecting "no more money and you're all useless" as the mantra from the new health and social care sec — along with insistent pushing of flawed 'reform' ideas."

In any case it's clear that if the funding limits set by Rishi Sunak's spending review remain in place the promise of 40 new hospitals will remain as a major broken pledge into and beyond the next election, whenever that may be.

# Outsourcing of NHS care led to increased deaths says new study

**Privatisation of the NHS has been found to correspond to a decline in care quality and "significantly" increased deaths from treatable causes, according to a study from researchers at the University of Oxford.**

The study – Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013–20: an observational study of NHS privatisation – published in The Lancet Public Health analysed data from Clinical Commissioning Groups (CCGs) in England and the researchers concluded that: "increased for-profit outsourcing from clinical commissioning groups [CCGs] in England might have adversely affected the quality of care delivered to patients and resulted in increased mortality rates".

It is the first study of its kind to look at the impact of the acceleration of privatisation brought about by Andrew Lansley's reforms in 2012; policies that forced local commissioning bodies to put contracts out to tender leading to an influx of private companies running NHS services.

It has implications for today, as although the recent health and care bill reversed some of the 2012 rules on commissioning, the government is still actively encouraging the use of the private sector to address the NHS waiting list that stands at a record 6.5 million people due to a legacy of over a decade of underfunding and the pandemic. This study now casts doubt on the safety of this approach for NHS patients.

An analysis of payments to private companies by 173 CCGs across England found that despite many commentators claiming otherwise, outsourcing from England's NHS commissioners to for-profit companies steadily increased in the period, rising to more than 6% of total commissioner spending in England in 2020, although there were considerable differences between CCGs. A total of £11·5 billion of outsourced contracts were received by for-profit companies between 2013 and 2020.

An analysis of the relationship between outsourcing and mortality rates found that an annual increase in outsource spending of 1% is associated with a rise in treatable mortality the following year of 0.38%, or 0.29 deaths per 100,000 people. A total of 557 additional deaths between 2014 and 2020 might be attributed to the rise in outsourcing, according to the researchers. These deaths were termed treatable deaths as they are considered to be avoidable with timely, effective healthcare.

A second analysis found no significant association between outsourcing and preventable mortality rates – those deaths avoidable with effective public health instead of medical interventions. Leading the authors to conclude that the relationship between outsourcing and treatable mortality found in the first analysis is not a product of general health outcomes in the population but is more directly associated with the quality of healthcare services.

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# NHS trusts lose out on shares for data deal


**NHS Trusts have found themselves with shares in a technology company that are virtually worthless as the company gets new owners and goes private. The trusts received the shares in return for data on millions of NHS patients.**

Twelve NHS trusts have data-sharing agreements with Sensyne, a company based in Oxford, which uses the data for AI-enabled analysis that can help speed up development of new medicines by pharmaceutical companies.

The data gives Sensyne access to detailed information on demographics, diagnosis, treatment, medication, biochemical and genetic tests and procedures, images, pathology, vital signs and genomics data for millions of patients.

The firm's financial difficulties became evident in late 2021, and in November 2021, Sensyne announced a formal sale process (FSP), which led to discussions with corporates and financial sponsors.

Even as the company's finances hit major problems, in December 2021, Cambridge University Hospitals NHS Foundation Trust signed a strategic research agreement with Sensyne giving the company access to three million patient records bringing the total of anonymised records in the UK to 12.9 million patients.

By April 2022, the company had secured additional capital of up to £26.3 million to continue, and its founder, the Labour peer Lord Drayson, had been replaced as CEO by Alex Snow. But, the new investors have taken the company private and shares will no longer be traded on the AIM (the section of the London Stock Exchange for small/medium sized companies).

Although the Ordinary Shares held by the NHS hospital trusts will continue to be a valid equity interest in Sensyne with full voting rights and rights to future dividends, the AIM delisting means there will be no public market in the UK on which the Ordinary Shares can be traded, therefore they now have negligible value. The Times reported that the company's rescue package will lead to existing shareholders "being wiped out", including the NHS trusts who supply the patient data that underpins the business.

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For many years those championing marketisation of the NHS, including successive Conservative governments, have claimed that competition and management autonomy would improve efficiency and performance of the NHS. However, these results suggest that such outsourcing of healthcare services has instead increased deaths among patients.

The reasons for the increase in mortality is still under discussion. Is it that the private providers are delivering worse quality care, for example, due to cutting costs, in order to bump up profits, either by reducing staff numbers or the levels of various qualified staff, or is there reduced adherence to guidelines?

Another possibility put forward by the authors is that outsourcing leads to intensified pressure across the whole health system. If profitable patients and services are cream-skimmed (i.e, the uncomplicated cases and services are preferentially selected) by for-profit providers, it creates a concentration of difficult treatments in public providers, but without any increased resources to tackle them.

Similarly, increased competition for contracts could result in private healthcare providers prioritising easily quantified outcomes such as waiting times at the expense of quality of care, resulting in higher patient mortality.

The authors acknowledge that there are limitations to the study, and more research is needed to determine the precise causes of the decline in healthcare quality in England, but they note that implication of their findings is that: "further privatisation of the NHS might lead to worse population health outcomes."

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HSJ has reported that the amount of data sent to Sensyne varies across the trusts. When questioned, not all trusts responded, with only five of the 12 trusts confirming they had sent data to the company, including Chelsea and Westminster Hospitals FT (1.5 million data items since 2019-20) and Milton Keynes University Hospital FT (180,000 data items since 2020). Five trusts said they had not yet sent data, others did not respond.

The trusts holding agreements with Sensyne have taken varying approaches to the changes at the company, according to HSJ.

A spokeswoman for Royal Devon University Healthcare FT told HSJ that the value of the trust's shares had been "reduced to negligible", whereas other trusts could not assign a value to the shares. Trusts who responded to HSJ noted that they are waiting to see what changes take place at the company before reviewing their positions.

As well as the shares, several trusts have received payments from the company, including Great Ormond Street Hospital for Children which received £50,000, and Royal Devon University Healthcare FT which is receiving a £165,000 grant paid in instalments.

Sensyne had a turbulent history during its short time as a public company. It was floated by Drayson in 2018, but a number of directors left, it had to settle an expensive employment tribunal with a former finance chief, Lorimer Headley for £380,000, and The London Stock Exchange issued a £406,000 fine for "serious failures" relating to the payment of executive bonuses.

***Sylvia Davidson***

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