The lowdown

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

Quarter of a million children denied mental health care

News about NHS children's mental health services hit a new low point this month, with research by The House publication finding a quarter of a million children being denied help by the NHS in the last year.

The House research used FOI requests to NHS trusts

continued on page 2...

Also in this issue...

...continued from page 1

across the UK and found that England has the worst data, with average community CAMHS waiting lists in February 2023 up by two-thirds in two years and children waiting on average 21 weeks for a first appointment. Across the UK waiting lists are up by 53% and the wait is 16 weeks, dropping to just three weeks in Wales.

The chances of under-18s seeing a professional was also found to vary across the country, often referred to as a post-code lottery. The House's research shows spending per child is four times higher in some parts of the country than others, while average waits for a first appointment vary by trust from 10 days to three years.

The record of Sussex Partnership Trust NHS Foundation Trust was highlighted by The House. It is the second biggest in the country with more than 30,000 referrals in 2022 across three counties.

The trust turned away almost 12,000 young people in 2022 and had an average wait for a first appointment of more than 20 weeks. It met just 6% of its target of 80% of cases seen within four weeks last December in Hampshire and 16% in Sussex, compared to 62% of its similar target for adults.

For those turned away, parents either pay up to £100 an hour for private therapy, if they can find it, or struggle on without professional help. The result is families torn apart by the disruption and stress, children missing years of schooling, and life chances dramatically reduced, and in too many cases loss of life.

Olly Parker, head of external affairs at the charity YoungMinds, told The House: "[The House's] figures show the system is in total shutdown yet there is no clear government plan to rescue it. In the meantime, young people are self-harming and attempting suicide as they wait months and even years for help after being referred by doctors. This is not children saying, 'I'm unhappy.' They are ill, they are desperate and they need urgent help. We hear about parents sleeping on their children's floors to keep them safe, children out of education for months and years while they wait for help. It is not an exaggeration to say it is life and death. How can we as a society allow this?"

The government announced plans in 2021 to implement a four week target for waiting times for mental health appointments as a national standard, however there is little sign of when this will be implemented and if it is implemented, it is unlikely that the standard can be met by the services in their current state.

This research by The House is the latest to be published in 2023, which paints a picture of a system that is letting down thousands and thousands of children.

In January 2023 a report commissioned by Look Ahead Care, a charity that provides mental health services across England, found numerous examples of children in mental health crisis and attempting suicide several times before getting a bed in an inpatient unit in England. With some under-18s waiting to undergo a mental health assessment on a children or adult ward and then waiting "for days or weeks" for a bed in a Camhs unit.

The report also highlighted how under-18s are seeking help at A&E for serious mental health problems because mental health crisis services are inadequate, even though emergency departments are not set up to deal with them. The increased use of A&E was backed up by NHS data analysed and reported by the Labour Party, which found that children suffering mental health crises spent more than 900,000 hours in A&E in England in 2022 seeking urgent and potentially life-saving help.

In March 2023, a report by the Children's Commissioner for England painted a bleak picture of a system where over half of the children with a mental health disorder did not receive treatment in 2021-22, and there was little or no improvement in young people's access to support, the quality of care they receive and their outcomes.

The report found in the best area in the country, Leicester, children receive treatment in an average of 13 days (between referral and second contact with the NHS), but in Sunderland that goes up to 80 days.

There is no doubt that demand for services far outstrips supply. Government data for 2021/22 shows a 39% rise in a year in referrals for NHS mental health treatment for under-18s to more than a million (1,169,515).

The pandemic certainly increased numbers, but factors such as social inequality, austerity and online harm, fueled growth before the pandemic and now continue to drive the crisis in mental health. Analysis of government data by the Centre for Mental Health found a strong link between poverty and young people's poor mental health.

Looking beyond waiting lists, to what happens to a child with a serious mental health condition 'lucky' enough to get a place in a residential unit, the picture is also bleak.

Mental health outsourced

Years of bed cuts in the NHS (from 23,515 in 2011 to 18,152 in late 2022), means that those children who need an inpatient bed, are very likely to be treated in a private hospital.

The Look Ahead Care report found that: "Private opera-

tors now provide most of the mental health inpatient care for children and young people who are deemed unwell enough to need a bed, but these cost up to £4,200 a week – far more than on the NHS."

The past few months have seen an investigation by The Independent and Sky News into one of the largest private providers, the Huntercombe Group (now Active Care Group), finding that even if a child is found a bed, they may not be safe or receive the care they need.

In late 2022, The Independent and SkyNew began making public the findings of their investigation. In a series of articles based on witness testimony, documents obtained by Freedom of Information request and leaked reports, they uncovered a shocking catalogue of issues in the units run by Huntercombe including sexual abuse, sedative medication as a form of control, excessive restraint, and inappropriate force used in relation to tube feeding.

Just one of Huntercombe's hospitals, Taplow Manor in Maidenhead, was behind 57% of the 2,875 sexual incidents and assaults reported to England's CAMHS over the past four years. Reported incidents can range from sexually inappropriate language to serious sexual assault and rape.

Police are also investigating the death of a young girl at Taplow Manor Hospital and the alleged rape of a child involving two staff members.

Systemic abuse

Whistleblowers spoke of such chronically low staffing levels that patients were routinely neglected, including being left alone to self-harm. The investigations have resulted in 50 patients coming forward with allegations of "systemic abuse" and poor care, spanning two decades at children's mental health hospitals run by the organisation.

The Independent/Sky News investigation prompted the government to launch a "rapid review" into inpatient mental health units. Yet this failure to keep children safe in private mental health units and treat them with compassion and dignity has been going on for many years.

Although the investigation focused on the Huntercombe Group, other private mental health hospitals, including Cygnet Healthcare, The Priory and Ramsay Elysium which dominate the market, have all been found to have provided poor care, including inadequate care leading to deaths in recent years, with hospital units closed or rated 'inadequate' by the CQC.

In January 2023, the BBC reported that three women had died at the Priory Hospital Cheadle Royal near Stockport in a three month period in early 2022, Beth Matthews, Lauren Bridges and Deseree Fitzpatrick, with the coroner citing neglect and failings by the hospital. This is just the latest in a long list of issues in recent years.

Cygnet has been repeatedly criticised by the CQC for unsafe and poor care. Most recently in March 2023 a Joint Domestic Homicide Review and independent mental health homicide investigation reported that the decision to discharge Jonathan MacMillan from a Cygnet Health Care unit in Maidstone into the community was 'flawed'. Following his release MacMillan stabbed his father to death in June 2019. The review found that the assessments completed while he was detained at Cygnet Health Care were inadequate.

As with The Priory, this is just the latest reported incident of a long list of problems at the company's hospitals over the years. There were so many reported problems at the company's hospitals, that in April 2021, NHS England singled the company out for a highly critical letter saying it will 'not tolerate failures'.

Over the past two years, inquests have been held on three deaths at Elysium Healthcare hospitals, which found failings by staff at the clinics.

These companies are being paid millions by the NHS for their services. The Priory received £440 million from the NHS and £179.8 million from UK social services in 2021, Cygnet, which is almost entirely dependent on NHS contracts, had revenue of £500 million in that year, and Elysium received £97.2 million in 2021 almost exclusively from the NHS. In 2021, The Priory reported profit of £109.7 million and Cygnet a profit of £26.3 million.

Whatever the outcome of the review into private mental health units, it certainly will not be able to rapidly increase the number of beds in mental health units, and so the NHS has no other option but to use those in the private sector.

This is a round-up of the latest reports and revelations in recent months that show the terrible state of children's mental health services in this country. Unfortunately, these reports, dire statistics, and shocking revelations, follow the previous few months of shocking statistics and reports, which followed….you get the picture.

The situation has been going on for many years, with thousands and thousands of under-18s denied access to help – leading to their future if not being destroyed, then certainly made more of a struggle and making it harder to fulfil their full potential. Imagine what those children could have achieved if only sufficient investment had been made over the past 13 years in supporting them, listening to them and treating them.

Sylvia Davidson

Ambulance strikes are about more than just pay

No amount of PR from NHS England and the DHSC can hide the fact that the industrial disputes hitting the health service are about more than just pay. New research focusing on the ambulance sector – set to be hit by strike action early next month – offers up damning evidence of workforce planning and capital investment failures that directly impact on patient safety every day.

This week's Observer carried an analysis based on FoI requests which revealed that ambulance trusts across England were experiencing high levels of staff turnover, particularly in the south, as paramedics and others increasingly leave for less stressful and better paid jobs.

The newspaper found that turnover rates at South Central Ambulance Service were particularly bad – 20 per cent for advanced paramedics, more than 40 per cent for dispatchers, 55 per cent for assistant dispatchers, and as high as 80 per cent for emergency call-takers and NHS 111 healthcare advisers – and that sickness absence rates were higher than before the pandemic.

Trust board papers for the South Coast East Ambulance Service, meanwhile, showed turnover was high enough – up to 40 per cent in some roles – to undermine attempts to employ enough staff in 999 frontline positions. And the South Western Ambulance Service admitted that staff turnover over the previous 12 months, for those performing some of the most pressured roles, was up to 30 per cent for clinical support desk staff and more than 50 per cent among emergency medical dispatchers.

The Observer's report echoed the results of the most recent NHS Staff Survey, which showed that almost 25 per cent of ambulance staff are planning to quit, and a growing proportion have become disillusioned with the standard of care offered by their workplace – a situation they ultimately have no control over.

Research commissioned by the Liberal Democrats, unveiled in January, hints at the full extent of falling staff numbers across the entire ambulance sector, with one service – in the North West – down by more than 650 full-time, clinically registered staff, compared to 2015. This month the opposition party followed up on its staffing research with new data showing that delays in ambulance response times resulted in hospitals declaring almost 4,500 peo-

ple 'dead on arrival' in December alone – a year-on-year rise of nearly 20 per cent.

Labour has produced its own research too. Last week it went down the FoI route to discover that one patient waited more than two days (65 hours, 38 minutes and 13 seconds to be exact) for an ambulance last December, and another spent 40 hours in the back of an ambulance outside a hospital until A&E staff could find a bed for them.

Impact of cuts in other sectors

And this week both opposition parties reported how ambulance staff are now regularly called on to help patients suffering from severe mental health issues, as overburdened NHS community services increasingly struggle to cope with more than a million people waiting to receive care and treatment.

However, all these indicators of workplace stress in the ambulance service and the corollary threat to patient safety rarely generate more than a scant response from the government. The Observer's reporter, for example, was only able to solicit from the DHSC this tired assertion, often repeated but never delivered on: "To ease the pressures on healthcare staff, the NHS will soon publish a long-term workforce plan to support and grow the workforce." Yes, but when?

That policy of promising but rarely delivering was on show earlier this month too, when the BBC – again having to resort to FoI requests – shot holes in a joint NHSE/DHSC two-year, £1bn investment 'blueprint' launched at the beginning of the year allegedly to support the emergency care network. As part of the plan, it was originally claimed, the size of the national ambulance fleet was to be increased by 10 per cent, with an influx of 800 new vehicles.

The planned increase turned out to be mostly illusory, though, as the BBC discovered. Figures from the eight ambulance trusts that responded to the corporation's FoI requests revealed that most of the ambulances being bought are replacements for existing vehicles, not additions to the national fleet, and purchases are often dependent on 'match funding' from NHSE, after that body imposed a pause on replacement programmes four years ago.

And with no accompanying details of how the extra vehicles would be staffed, the King's Fund thinktank understandably questioned what impact they could possibly have, given that handover delays at A&E departments – not vehicle shortages or breakdowns – were the major factor in driving poor ambulance response times, Only last week the BBC reported response times by the Welsh Ambulance Service were the second worst on record, but at the same time handover delays at major A&E units across the principality were up 51 per cent on the previous month.

Another initiative aimed at improving response times came in February this year, when NHSE asked ambulance trusts to 'grade' emergency calls and divert those not involving threats to life and limb elsewhere – potentially to GP surgeries or even pharmacists. But with both those sectors already under pressure it's not clear how much potential this initiative really has to ease ambulance waiting times and handover delays.

The wider picture

But the problems ambulance staff have to deal with are, of course, part of a wider picture. As Sir Julian Hartley – chief executive of the ambulance trusts' representative body NHS Providers – warned when the 'grading' initiative was unveiled, "Pressures in the ambulance service are linked to pressures across the whole system. We need to focus on reducing high bed occupancy, increasing bed capacity and tackling delayed discharges through increased investment in social care and community services."

The impact on patient safety of the government's failure to properly resource the ambulance service with adequate staffing levels and investment has been well documented in the past – see The Lowdown's own investigation two years ago – and this, alongside pay, remains a core issue for those ambulance staff still set to strike next month, striving to get a better deal for patients as well as themselves..

Martin Shelley

Hundreds of NHS anaesthetists unable to get jobs

This year 350 trainee anaesthetists were unable to get posts for the next stage of their training (higher specialist training ST4) in the NHS, despite there being a shortfall of 1,400 consultants and speciality doctors in anaesthesia, according to the Royal College of Anaesthetists (RCoA).

Despite the shortfall of anaesthetic staff in the NHS, which the RCoA has estimated means around 1 million operations are unable to take place, the HEE does not fund enough training places to meet demand from eligible doctors. There is a mismatch between the number of training places available, which is determined by funding from Health Education England (HEE), and the number of doctors wishing to specialise in anaesthetics.

The 350 doctors that did not get a training place are now unable to progress in their chosen speciality, despite already completing 3 years of training and will have to take positions as non-consultant speciality doctors.

President of the RCoA, Dr Fiona Donald said in a statement from the RCoA:"At a time when there are over 6 million people in England alone waiting for procedures, and given that most operations require the skills of an anaesthetist, it is vital to the recovery of the surgical backlog that we continue to grow the number of anaesthetic doctors. Anaesthetists in higher specialist training posts make an enormous contribution to the health services during their training. Many will be eligible to be consultants within 4 years at which time they will help to reduce the shortfall in workforce numbers"

The statement also noted that the college has been "campaigning tirelessly" to increase the number of training places.

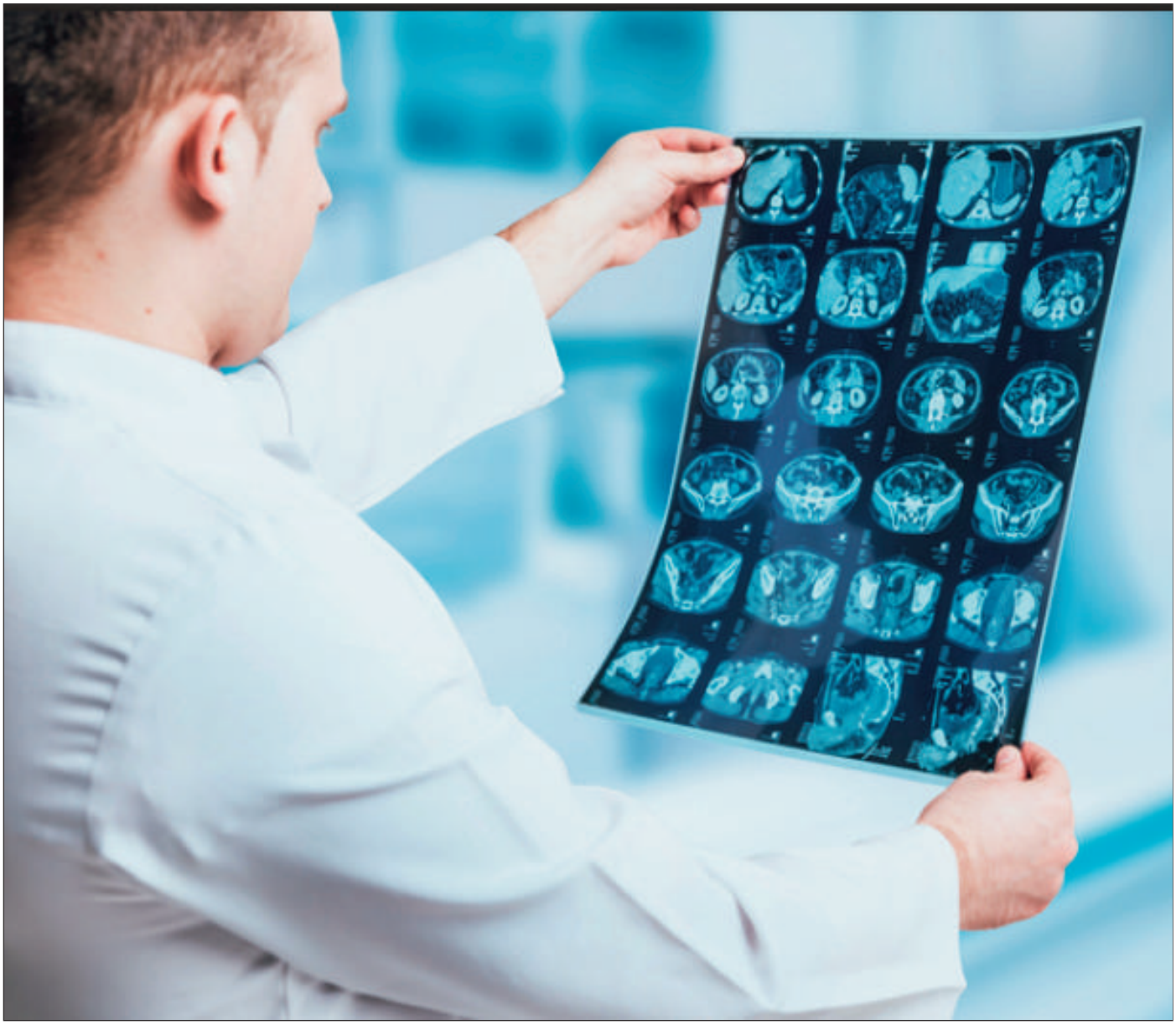
In May 2022, the college did succeed in prompting the HEE to increase numbers, with 100 extra training places, 70 for anaesthetists and 30 for intensivists.

The increase in numbers was prompted by the college's report – The Anaesthetic Workforce: UK State of the Nation Report – which analysed workforce data and concluded that the shortfall of 1,400 anaesthetists was already causing 1m operations to be cancelled each year.

However, the RCoA report also warned that "anaesthesia is facing a perfect storm of limited training places, poor retention and an ageing workforce" and at the "current insufficient growth rate, the NHS will have a shortfall of 11,000 anaesthetic staff by 2040 to meet this additional demand." If this shortfall is not addressed around 8.25 million operations will be prevented from taking place.

Anaesthetists are critical of the NHS's attempts to clear the backlog of surgery. The NHS's waiting list for procedures, the vast majority of which will require the services of an anaesthetist, stands at over 6 million.

In addition, anaesthetists are needed within maternity departments, for time-critical Caesareans and epidurals, and they need to be available 24/7 to provide airway and critical care skills during all major emergencies, whether adult, paediatric or as a result of major trauma..



Integrated Care Boards financial squeeze set to tighten

Key points
– Pressure has been applied on NHS leaders to submit "unrealistic" plans in order to publish balanced budgets
– Future plans look likely to rely on unachievable savings in the face of rising demand and costs
– This year many Integrated Care Systems relied upon one-off savings, with next year looking tighter still

There is a disconnect between the presentation of the national picture and the local reality on the ground of unnecessary deaths in A&E, delayed discharges and a continuing crisis in staffing.

Before the 42 Integrated Care Boards established last July have fully gathered details of their financial performance over their first nine months, it's already clear that many if not all face a much tougher struggle to stay afloat in the new 2023/24 financial year.

NHS England heard at their March Board meeting that 16 Integrated Care Systems were forecast to overspend compared to their plan for 2022/23, with a combined forecast overspend of £517m. The Board was assured that the deficits equate to less

than 1% of total allocation, and seems to have asked no more searching questions about how these results were achieved.

However, a new Lowdown survey of 21 ICBs (in North East and Yorkshire, North West, South East and South West) suggests this may well be an underestimate and unrealistically optimistic on the situation ahead.

While in some areas there is little or no useful information publicly available, it shows that the reality in most areas is that deficit figures have only been reduced to the reported level after additional funding of £1.5 billion was distributed towards the costs of inflation by NHS England, and by resort to one-off "non-recurrent" measures by trusts or ICB finance directors, which effectively conceal the scale of the underlying gap between cost pressures and resources.

The problem is then the even larger challenge to bridge the gap between needs and resources the following year.

Tougher this year

NHS England bosses know full well that however tough the financial regime has been for 2022/23, it is set to get even tougher in the next two years – in which the NHS is expected to deliver £12 billion in "efficiency savings", while reducing waiting times and waiting lists and somehow coping with problems including:

– continuing high levels of cost inflation
– under-funded pay awards
– staff shortages that force up spending on agency staff
– thousands of beds filled with Covid patients (for which there is now no additional funding)
– and thousands more filled with patients who cannot be discharged for lack of community health and social care

Last autumn NHS England warned ministers before the budget that it faced a £7bn deficit for 2023/24, but Chancellor Jeremy Hunt's response was to increase spending by less than half this amount.

The HSJ, with the benefit of leaked information, revealed early in March that the first draft of plans for 2023/24 projected a combined deficit of £6 billion, almost half of which came from just two regions, the Midlands (£1.5bn) and the North West (£1.4bn). The HSJ reported one 'senior source at an ICS' saying the deficit was the "biggest… by some way" they had seen at this stage in their 25 years in the NHS, and predicting the planning round would last until July.

However, it seems that the main focus of NHS England has been on closing their eyes and putting their fingers in their ears, suppressing public evidence of bad financial news, while pressing behind the scenes for improbably large "savings".

The Lowdown reported how back in November NHS England set up tough new rules to deter ICB finance chiefs from giving early reports of any negative change in their financial situation – effectively encouraging ICBs to cover up reality and delay any unpleasant news (and any consequences) until the last minute.

This has further developed into moves tantamount to urging ICBs to lie about the reality they face, with NHS England subsequently also bouncing back revised plans for deficit budgets in 2023/24, which according to the HSJ still collectively add up to a deficit of £3 billion.

Turning the screw on Trust bosses

Now the HSJ reports NHS England is applying new pressure directly on to trusts which have failed to submit a balanced budget for 2023/24. NHS England's chief finance officer Julian Kelly has told chief executives that around a quarter of trust submissions for 2023-24 were still unacceptable.

Sources told the HSJ that NHSE was now "turning the screws," going through trust plans to identify further savings, and applying "intense" pressure. One acute truss boss said: "Every trust in the country is having to go back and take more out of its budget."

But while NHS England tries to ratchet up the targets for cost savings, Nuffield Trust research suggests that trusts have generally been unable to deliver savings of much more than 1 percent.

NHS England is demanding new plans be drawn up which, like last year, appear to balance the books by assuming increasingly unrealistic levels of savings can be made.

The whole process of developing plans for the new financial year has largely been conducted behind closed doors, with ICBs revealing only the most sketchy details of their plans to Board members, and keeping the public in each area in the dark. Whenever this has been done in recent years (as with the development of Sustainability and Transformation Plans in 2016) the result has in almost every case been rubbish plans that are swiftly discarded as unworkable.

The HSJ now cites one example from North East and Yorkshire in which savings of seven percent of the total ICS turnover are assumed, and one ICS leader responding: "How anybody is going to do 7 per cent without hitting patient care is beyond me. This isn't planning, it's just making figures up."

It also quotes a chief financial officer in another system commenting: "We're into numbers now that are not doable by just efficiency, they have to be cuts." Although there are next to no details of how the claimed savings have been made so far, or how they are being planned for the new financial year, the Lowdown's survey finds evidence that supports this view.

Serious plans for efficiency seem to be few and far between – and some trusts and local systems have been relying on reduced levels of elective activity (some areas still below 2019 levels) to keep their costs down – quite the opposite of an efficiency saving.

One-off schemes

Many ICBs have been relying upon non-recurrent or one off sav-

ings to cover a large proportion of their underlying deficit, raising the question as to how future costs will be met.

In North East and North Cumbria, for example, where a failure to deliver £64.5m of recurrent "efficiency" savings was partly covered by £57.5m of non-recurrent measures, only one of the 11 providers forecast achievement of recurrent savings (p197).

In Greater Manchester, just £22m of £119m forecast full year savings are recurrent, and the HSJ has published a £paywalled report that the underlying deficit is as high as £800m. The financial problems in this early implementer of 'devolved' power and integration of NHS and social care are obviously severe.

By month 9 the system was in deficit by £67.8m against a planned deficit of £8.0m. As a result, the ICS has been placed into a formal financial recovery process, alongside crisis measures including a continuing vacancy freeze with a rigorous process to support "recruitment to business critical roles only," and the "launch of the STAR process to review any new expenditure requests at an earlier stage in the decision making and procurement process."

The real picture is harder to decipher in some local systems, such as Cheshire and Merseyside, where the ICB itself is projecting a substantial surplus, largely at the expense of providers (most commonly the acute trusts) facing substantial deficits (p56).

Frimley ICB in the South East is projecting break-even, largely on the back of one-off measures including a lucrative land sale.

In Bath, NE Somerset, Swindon and Wiltshire (BaNESSW) a planned ICB surplus of £51.1m "has been transferred to cover the planned provider deficit" (p58).

By contrast in Bristol, North Somerset and South Gloucestershire (BNSSG) the ICB admits it is expecting to deliver NONE of its "System Transformational Savings Programme" target of £13m

Acute and emergency services

Pressures on acute and emergency services are central to the concerns and the deficits in many areas, with acute trusts generally facing the biggest problems. For example in Humber and North Yorkshire: "[Hull University Teaching Hospitals Trust] started the year with an underlying deficit of £43.5m … additional in-year pressures will move this to a position of between £50m – £56m.

North East and North Cumbria ICB reports "There are 2 providers with long standing financial issues and forecasting a combined deficit of £64.14m, which the remaining providers will need to cover in order to deliver the system plan." (p294)

Four Cheshire and Merseyside acute hospitals have combined deficits of £76m: the Countess of Chester Hospital Trust (which planned for a £3.1m deficit, but the actual is £20.6m); Liverpool University Hospitals £29.9m; Mid Cheshire Hospitals NHS Foundation Trust Planned £11.7m; Southport and Ormskirk Hospital £13.7m.

The deficit in Liverpool University Hospitals is put down to the need for 78 escalation beds, (down from 115) to meet high levels of emergency need: and "corridor care" remains in place, and a significant driver of additional staffing requirements: meanwhile elective activity levels remain below the pre-pandemic levels. In Mid Cheshire the Trust is experiencing increased unplanned demand, requiring additional escalation beds and newly opened discharge lounge. Wirral University Teaching Hospitals has also had to open 64 escalation beds, and use "corridor care" in the Emergency Department.

In the South East, provider deficits in Hampshire and the Isle of Wight total £70.8m at month 11. In Buckinghamshire, Oxfordshire and Berkshire West acute hospital trusts are running combined deficits of almost £39m.

Human cost of A&E delays

However, money is not the only measure of a system under pressure, and the Royal Cornwall Hospital Trust is the only one in this survey to call attention to the increased risk these delays pose for patients. Cornwall ICB's only acute hospital, Treliske in Truro, has seen a worrying further drop in A&E 4-hour performance, from 44.26% in January to 41.99% in February. The ICB notes:

"Ambulance handover delays have not reduced in line with the planned trajectory … Evidence indicates that when handover delays exceed 1 hour there is a direct correlation with patient harm. In January, the total time patients spent over 4 hours in ED equalled 25,591 hours equating to 34 cubicles per day and 511 extra nursing shifts for the month.

"For every 82 patients who stay more than 8 hours in ED there is an extra death in the next 40 days. NHSE data has recorded 13,924 episodes of excess 8 hours in past 12 months this equates to 170 excess deaths due to ED crowding in the past 12 months."

Delayed discharge

Other delays also have a human – and a financial cost. In Kent and Medway the Month 9 deficit of £61.9m is blamed on the number of "medically fit for discharge patients in beds" which requires escalation beds "which have remained open for the whole year", because the system has been unable to close them: they are staffed by medical and nursing agency.

For Sussex ICS the problem is "expenditure on Continuing Healthcare Services running at around 20% higher compared to 2021/22, …. The significant forecast of £20m overspend is around 13% of this year's budget." In BaNSSW ICB the problem is mental health and community services: the Avon and Wessex Partnership trust are reporting a £29.6m deficit, but with non recurrent sources supporting the position. It's not clear how they are nonetheless forecasting to break even at year end.

In BNSSG the issue has been vainly seeking savings from ear-

lier discharge of patients. The ICB notes that despite high hopes: "Whilst there is demonstrable benefit … in terms of impact of the key investments in Discharge to Assess and Home First schemes from a performance point of view, this has not translated to cost release, but has been mitigated by non-recurrent measures in-year."

Staff shortages

Another major problem in almost all areas is staff shortages, combined with an unrealistic cap on spending on agency staff imposed by NHS England. Some ICSs have overshot their targets by considerable amounts, such as Cheshire and Merseyside where £43m above plan equates to almost 4% of the system's total pay bill.

Lancashire and South Cumbria ICB's "state of the system" report notes spending on "expensive agency staff" adds up to more than £300m a year.

BaNESSW ICB notes spending on agency "over double planned levels, and bank at 98.5% above," while in the south west Cornwall Foundation Trust reports overspending on agency staff of £18.8m above a £3.4m maximum target!

Costly private sector

But many ICBs are also including costs of contracting out care to private hospitals and providers as reasons for their overspending.

North East and North Cumbria forecast overspending on "independent sector" contracts at £21m. However "Additional funding of £5.7m has now been received from NHSE in respect of additional IS activity performed in the first 6 months of the year. Further information is awaited on any additional funding for the second half of the year."

Humber and North Yorkshire ICB "continues to experience financial pressures in relation to the price and volume of CHC [Continuing Health Care] packages, prescribing inflation and contracting with the independent sector." Cheshire and Merseyside reports overspending on independent sector Community Services, and using "independent sector capacity" to treat patients needing gastroenterology, ENT, general surgery and orthopaedics.

Greater Manchester includes "private sector surgical activity" in its list of "operational pressures" and forecasts £12m overspending on Independent Sector Acute activity "principally linked to two ophthalmology providers SPA and Optegra".

Lancashire and South Cumbria ICB notes "Independent sector acute costs are forecast to overspend."

In the South East, Kent and Medway makes clear it utilises independent sector capacity only "for less complex patients."

Devon ICB reports spending £33m of its £1 billion acute sector budget on independent sector provision, to treat "suitable" orthopaedic patients "who are willing to move provider" … but it doesn't say how far or where they have to go.

Dorset ICB complains that "activity with our Independent Sector Provider continues to overspend against plan" – "mainly driven by overperformance at Spa Medica (ophthalmic patient choice) and BMI." Nonetheless they are responding to increased demand and staff shortages in audiology by outsourcing to Specsavers , even though they can "only assess and fit simpler cases". Mental health beds have also been block booked at Marchwood Priory Hospital "to minimise distance away from Dorset."

Gloucestershire reports receiving extra funding from NHS England to cover the costs of "over delivery by the independent sector providers". However Cornwall and Isles of Scilly ICB admits to having problems: the mental health acute beds it has block booked in Exeter have been rated as "requires improvement" in all areas by CQC.

Seeking NHS solutions

But while it's clear most of the ICBs who reveal information on use of the private sector are using it to fill gaps in their own capacity and staffing, in South Yorkshire and Bassetlaw ICS there is a glimpse of what a progressive alternative might be. Plans are well advanced for a new, NHS-run Montagu Elective Orthopaedic Centre (MEOC) in Mexborough, with the specific ambition of repatriating work from the private sector.

Doncaster and Bassetlaw Teaching Hospitals trust has developed the business case on behalf of the ICS, "together with its partners The Rotherham Hospital Foundation Trust and Barnsley Hospital Foundation Trust. Future developments may include capacity for Sheffield patients, potentially including paediatric activity."

"There will be training opportunities and career progression into new and advanced roles. Career progression opportunities will be available to retain and ensure experience and knowledge. The MEOC facility will have good staff facilities and be well equipped. The whole unit will be run as a single service, supporting development of a cohesive team thriving on excellent outcomes. The plans to further develop the MEOC facility beyond this proof-of-concept stage into a larger Centre of Excellence will provide staff with further opportunities and an exciting future."

Another similar scheme is at Hallamshire Hospital and focusses on the Sheffield waiting list and includes HVLC orthopaedics and enhanced recovery.

And NHS solutions are also being explored in Lancashire and South Cumbria, where a backlog of more than 2,500 cases awaiting assessment for Continuing healthcare (CHC) – packages of care has built up. The ICB is now looking to "quickly build an in-house service to manage CHC in a consistent way across Lancashire and South Cumbria so we can quickly fix this backlog.".

John Lister

MPs question private sector contribution to NHS elective recovery

Two weeks ago, the Lowdown took a detailed look at the situation of the private healthcare sector.

We were seeking to understand why – after 13 years of policies promoting privatisation and driving waiting list patients towards private treatment – Rishi Sunak should be contemplating new laws to compel NHS bosses to send more patients for treatment by the private sector.

But in the wider search for information for that study it became clear that it's not just campaigners and trade unions who have concerns over the impact on the NHS of relying on the capacity of the unevenly-spread patchwork of private hospitals and clinics: questions are also being asked by the Commons Public Accounts Committee.

Despite receiving an extensive written submission from the Independent Healthcare Providers Network (IHPN) singing their own praises, the cross-party PAC was clearly unconvinced by their account, and by what they heard from NHS England about their elective recovery plan (which focused heavily and repeatedly on use of the private sector but made no attempt to explain the possible drawbacks of this policy).

The PAC's Report, Managing NHS backlogs and waiting times in England was published on March 1. It notes:

"NHS England's elective recovery programme partly relies on initiatives which have potential but for which there is so far limited evidence of effectiveness… [and] their impact on other parts of the health and social care system, and how they will work on a greatly expanded scale."

The Committee called on NHSE to write to it to explain "the extent to which these initiatives have so far generated genuinely additional activity, rather than simply displacing activity elsewhere in the NHS."

That is the kind of question the private sector hates. That's because their big claim to have played a useful role as a "partner" of the NHS rests entirely upon the period from 2003 to 2010, when the New Labour government chose to invest in new privately-run "Independent Sector Treatment Centres" – to create "contestability," and a lop-sided "market" in elective care (in which only the private sector was allowed to compete) – rather than in expanding the NHS. It was a license to print money, guaranteeing profits for private companies, who took only the least complex patients, and were given preferential long-term contracts and paid an average of 11.2% above the NHS cost for each treatment.

Back in 2006 the Public Accounts Committee of the day found gaping holes in the arguments put forward for further expanding the network of ISTCs, which only ever played the most minimal role in the reduction of waiting times, while the main brunt of the work was done by the NHS.

The PAC then was unconvinced by the private sector's bluster: "The Department of Health has carried out analysis of the possible effects of the ISTC programme on NHS facilities, but it has refused to disclose the analysis to us. Phase 2 ISTCs may lead to unpopular hospital closures under 'reconfiguration' schemes.

"… There was also considerable scepticism about whether the ISTC programme represented value for money. We found it difficult to make an assessment since the Department would not provide us with detailed figures on the grounds of commercial confidentiality."

Demands for higher return for NHS work

Parliamentary questions casting doubt about the effectiveness of contracting work out to private providers clashed head on this week with latest demands of the major private hospital chains, Circle/BMI, Ramsay and Spire for increased payments for each treatment from the NHS. The HSJ has revealed that this plea for substantial increases in the tariff of prices paid by NHS England has come with the threat that if they don't get a big enough rise the companies will pull away from further NHS work.

This is dangerous territory for the private sector: if they achieve their price increase they immediately wipe out one of their main arguments justifying their role, which has been that they take patients at the NHS tariff price – and therefore are no more expensive.

NHS England and the acute trusts have already knuckled down and accepted a tariff that only partly covers the costs of recent and ongoing inflation, and the government's tough line in seeking to face down pay demands from nurses and doctors has been (spuriously) linked to the need to bring down the rate of inflation. For them to concede now to the private sector's demands would further inflame anger in the NHS workforce.

But of course if they don't succeed, the bluff of the private hospital bosses will be called: if they walk away from their lucrative NHS contracts they know that the actual private market (insured and self-pay patients) has not significantly grown beyond the level it reached before the pandemic, despite the mushrooming size of the NHS waiting list. The cost of living crisis, and inflated cost of private operations, has limited their already pretty small market – and they would be stuck with thousands of empty beds.

Fallout on patient care and services

The fight over pricing is not the only problem the private sector faces. Serious clinical concerns have been raised over the consequences of the expansion of privately-delivered eye care, the largest single area of private sector activity, with specialists calling for more investment in "comprehensive NHS services."

The HSJ reports a "workforce census" survey carried out by the Royal College of Ophthalmologists found almost 60 per cent of respondents believed independent providers were having a "negative impact" on care and ophthalmology services in their area, with problems including cases being passed back to the NHS when IS care failed, and the NHS being left with a greater concentration of more serious, and costly, cases while the IS focused on routine cataract operations.

All this raises the broader question of how many NHS operations are now being carried out in the private sector, and whether, indeed this does represent additional capacity or simply the private sector carving out a slice of the NHS budget in the absence of any NHS capital to expand.

Doubts over sector's growth

Submissions to the Public Accounts Committee, all produced last November, show the growth of private sector involvement since the peak of the pandemic, but also how uneven that growth has been and the limitations of the private sector in handling much more of the NHS caseload.

The IHPN submission wants on the one hand to boast about its success, noting: "in August 2022, [waiting list] activity delivered by independent providers was 16.3% higher than it had been in August 2019, pre-pandemic."

But it also repeatedly stresses the unused private sector capacity, the "appetite" for more NHS contracts and the missed opportunity for further work to be commissioned:

"independent providers have offered to deliver increased capacity for NHS-funded activity to help reduce NHS waiting lists. Unfortunately for the past 18 months, and despite this capacity offer, NHS activity delivered through the independent sector has struggled to return to pre-pandemic levels across almost every specialty (ophthalmology being the notable exception)."

The private sector lobby group blames local NHS bosses for defying NHS England guidance and holding on to scarce financial resources, claiming there is a "disconnect between the policy direction coming from the Department for Health and Social Care and NHS England, and the implementation of these policies on the ground."

It also claims the payment system is unfair to the private sector, and effectively discourages additional NHS referrals in the precarious financial situation of trusts and commissioners. It complains bitterly that most cash-strapped NHS systems "appear to be prioritising the process of transferring patients to the independent sector from existing waiting lists," [as many people would hope would be the case] rather than prioritising the abstract notion of "patient choice".

By contrast the NHS Confederation, representing NHS commissioners and providers, points to the profound limitations of using the private sector:

"The independent sector is being commissioned to take on more procedures to tackle the waiting lists in the NHS. Whilst this is welcome as it can alleviate the pressure on the NHS, the independent sector will not have the capabilities, workforce or capital to take on the cases which are more complex in nature and acuity.

"The NHS will likely be left with the more complex and costly procedures to carry out because of the expertise and infrastructure needed. People on waiting lists, many of whom have been waiting several months, have deteriorated in their health and will need more complex care than they did when they first joined the waiting list. Due to this, these patients will not have the choice to use the independent sector, and this further complexity of care means health inequalities worsen."

The Confed goes on to point out that both the NHS and private sector "are recruiting from the same pool" of qualified staff, so the growth of the private sector undermines the NHS. And it highlights the lack of capital for investment to expand or to maintain and rebuild or replace ageing hospitals and clapped out equipment as factors limiting NHS capacity.

Mixed views

NHS Providers, representing trusts and foundation trusts, also highlighted the financial constraints and fears of a majority of trust bosses that they lack the resources to achieve the targets set for them by NHS England, as well as the problems and limitations of using private providers:

"Trusts have mixed views about the use of the independent sector in tackling the waiting list. Firstly, private sector provision is not uniform across the country and therefore access to the independent sector isn't always available. There is a concern that a reliance on the independent sector could further widen health inequalities as independent sector provision is more likely to be present in affluent areas. […]

"The role of the independent sector is limited … Independent sector provision largely covers high volume, low complexity cases as most independent sector providers do not have intensive care capacity. Therefore, independent sector provision can only really accommodate low risk patients."

The submission from the Health Foundation helps to answer a question often misunderstood by campaigners: how much NHS care is privately provided, and whether its role is growing: the answer seems to be that private hospitals have a growing share of a reduced market:

"Before the pandemic, ISPs [Independent Sector Providers] delivered around 12% of total NHS-funded planned treatments requiring hospital admission and 7% of outpatient treatments. As of March 2022, the share of care delivered by ISPs was higher than it was before the pandemic. For care requiring hospital admission, the volume of ISP provided care grew by 9%, equating to an increase in share from 12% to 16%. At the same time, the total number of NHS and ISP provided treatment was 14% lower."

Choices patients actually want

Health Foundation survey data also shoots down one of the private sector's favourite arguments for patient choice to use providers outside the usual area. In fact the desire for choice was to be offered local treatment:

"89% support giving patients more choice over where they are treated, for example, the option of being treated in a hospital in their local area if there is a shorter wait."

Moreover there was a clear majority (81% of those surveyed) in favour of waiting lists to be prioritised by the urgency of the condition – favouring the NHS and its resources – rather than length of time on the list.

The Health Foundation submission also noted that while there are 250 ISPs providing elective care at Independent Sector Treatment Centres (treating only NHS patients) and private hospitals, ISPs tend to be narrowly focused on particular treatments (one in four, 23% covering only ophthalmology).

A previous Health Foundation study had shown the uneven spread of ISPs across the country, the reduction in numbers of NHS patients treated in some specialties compared with the significant rise in ophthalmology, and the questions that arise over growing inequality of access to services.

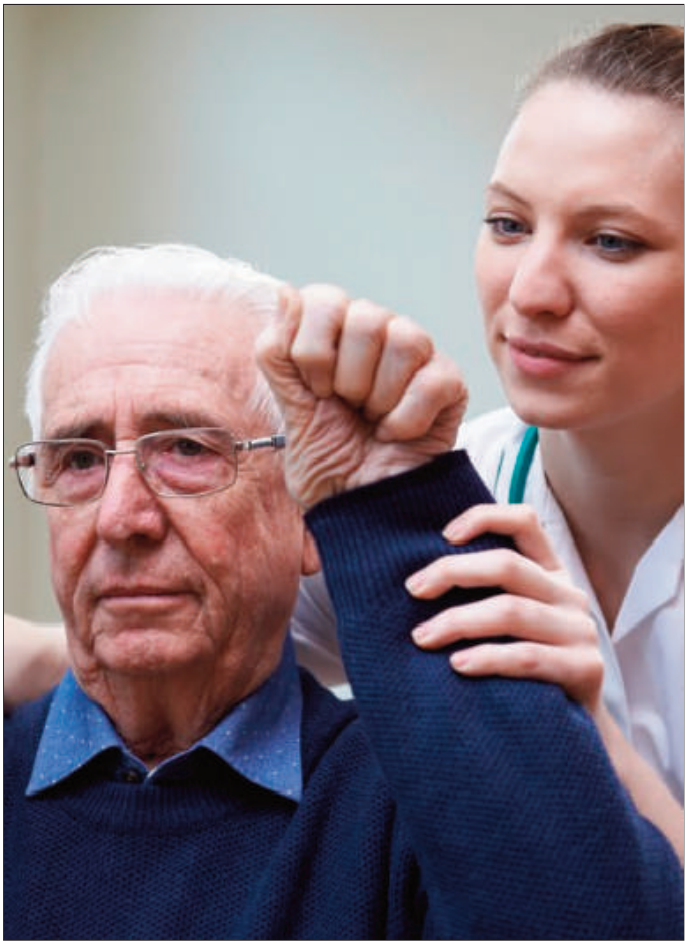
Their latest submission concludes with the telling question that has now been raised by the Public Accounts Committee:

"Could the increased proportion of treatments being delivered by the independent sector be helping to limit waiting list growth, by delivering care that otherwise could not be delivered by the NHS? Or does this represent displacement of activity from the NHS to the independent sector?"

The limitations of the private sector are therefore exposed once again, as they seek to jack up the prices they are paid without drawing too much attention to the fact that whatever growth they have enjoyed in the past 13 years has been a product of a Tory government's costly and discredited 'reforms' and the prolonged austerity squeeze on the NHS.

Two decades of experiments in utilising private providers has shown only that whatever minor role they may play in acute services, the buck for complex care, emergency care and chronic care stops with the NHS. There is still a lot of it to defend.

Hewitt review misses need for far-reaching change



Richard Bourne discusses how past policy failings still haunt the current health policy debate, as he explores the changes proposed in Patricia Hewitt's review of the integrated care system and the recently published paper by Chris Ham on the political failings in NHS policy – 2010-20.

Even at the high point of 2010 the NHS and social care system faced severe challenges. The basic NHS principles (universal, comprehensive, free at point of need and tax funded) were strongly supported and the NHS did well on international comparisons, but the much improved NHS had not adapted to the new reality that millions could live independent lives for many years with appropriate care and support – it was rooted heavily in curative care.

Whilst the NHS came near the top of health care systems in international comparisons, on some measures of quality of care the NHS performed badly.

The unspoken reality was that the NHS delivery model, loosely based on a pretend market, was dysfunctional and badly managed. The economy was being impacted by poor health. The Treasury regarded healthcare as a cost to be cut, not as an investment.

It is all far worse now. Years of austerity funding, and the worst thought-out reorganisation in NHS history has done huge damage. The pretence of the Conservatives going into the 2010 government that it was now "the party of the NHS" never translated into anything serious.

And after more than a decade of austerity, last year's inept attempt to reverse the worst of the coalition government's 2012 'reforms' is already unpicking.

Moreover looming large over the issues in the NHS is the disgrace that is our social care system. After decades of failure to address the problems, it does not work for those that need care, for the staff that deliver care, or even for many of the organisations that provide care. Multiple promises to "fix" social care have all been shown to be hollow. Many who need it most are denied any care, or receive inadequate care.

Two new perspectives

Against this background we have had two significant publications. Firstly, Prof Chris Ham's synopsis of the woeful failures of the post-2010 governments to stem the severe decline in services.

That sets the context for the second publication, which is an attempt to address the issues around the "new" NHS of Integrated Care Systems (ICSs). To be fair many of the 36 recommendations in the Hewitt Report are sensible although they are light on how things will be done.

In particular Hewitt argues for an approach that accepts the need for the NHS to adapt and to fit into a system designed to improve wellbeing, with more being spent on prevention and a shift to greater emphasis on community and primary care.

It argues for more stable funding, a longer term and more coherent way to use capital, and for better ways to use funding through pooling of budgets and for the proposed cuts to ICS management costs to be reconsidered.

It also puts the case for better use of data, and for employing more NHS staff capable of using that data to better manage and to improve outcomes. It supports a stronger role for patients and the public.

Critics might suggest it is an NHS solution to problems the

NHS does not understand and, as ever, it is focused on the vested interests especially those of the large provider Trusts. It also relies on opinions drawn from talking to 'stakeholders' (the usual suspects) rather than data and analysis, and little evidence of engagement with patients, carers, staff, service users or even voters.

A Trojan Horse?

There is no support for the minority view that ICSs are a Trojan Horse for planned Americanisation. Hewitt argues that rather than disrupt yet another reorganisation, the ICB/ICP setup that has now been put in place should be adapted and made to work, reflecting at least a salute to devolution and localism.

However the Hewitt Review has not met with much enthusiasm, and looks like being shelved. The Treasury is unlikely to move from its short term commitment, seeking cuts rather than investment to meet the rising cost pressures on the NHS. NHS England in turn will not relinquish its top-down culture of performance management and direction. Ministers will not accept localism, and will continue to try to micro manage; and the ICS's will be made up of those who toe the line and look upwards.

More and more will be poured into hospitals, and the power and influence of community/primary care will continue to decline. Desperately necessary capital investment will be as likely to arrive as the now mythical "40 new hospitals."

And as a vehicle for real reform (whatever that means) Hewitt's review does not go far enough. A new approach is vital.

The care system is in crisis. It needs some short-term actions to resolve immediate problems, mostly around workforce. It needs a government that believes in the founding principles, and will support them with funding.

But more money, more staff, or even more ambulances are not the solution – or at least not the whole of the solution.

The most important issue of all is the need to be honest about the NHS and its weaknesses as well as its strengths:

it cannot function effectively without a public health system to minimise the numbers developing avoidable health problems, along with proactive measures to improve the living standards and conditions of the poorest and reverse the recent downturn in healthy life expectancy.

hospitals and primary care services cannot function effectively without the development of a universal and accessible National Care Service in place of the current cash-starved, dysfunctional and largely privatised shambles.

despite the empty rhetoric about "integration," hospital and community health services cannot function effectively when the NHS budget is carved up into contracts which allow the private sector to cherry pick the least demanding services in the quest for profit, while NHS trusts are left with all of the emergencies and most costly and demanding cases. The outsourcing of clinical and support services to private contractors undermines the viability of NHS providers, and should be halted and rolled back as contracts expire.

Only then can evidence based solutions allow some honesty about the expectations of the electorate on just how long they have to wait and how much they may have to pay in taxes!.

DONATE

If you've enjoyed reading this issue of The Lowdown please help support our campaigning journalism to protect healthcare for all.

Our goal is to inform people, hold our politicians to account and help to build change through evidence-based ideas. Everyone should have access to comprehensive healthcare, but our NHS needs support.

You can help us to continue to counter bad policy, battle neglect of the NHS and correct dangerous mis-information. Supporters of the NHS are crucial in sustaining our health service and with your help we will be able to engage more people in securing its future.

We know many readers are willing to make a contribution, but have not yet done so. With many of the committees and meetings that might have voted us a donation now suspended because of the virus, we are now asking those who can to give as much as you can afford.

We suggest £5 per month or £50 per year for individuals, and hopefully at least £20 per month or £200 per year for organisations. If you can give us more, please do.

Please send your donation by BACS (54006610 / 60-83-01), or by cheque made out to NHS Support Federation and posted to us at Community Base, 113 Queens Road, Brighton BN1 3XG.