THE lowdown

Health news, analysis and campaigns.
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Informing, alerting and empowering NHS staff and campaigners

NHS bill for repairs soars 14% to £12bn

John Lister

New official figures show England's NHS backlog of maintenance has rocketed by **13.6%** in the last 12 months to a massive **£11.6 billion**.

The annual Estates Returns Information Collection makes clear that this total is over and above what should be routine spending on maintenance and replacing/upgrading clapped out equipment:

"'Backlog maintenance' is a measure of how much would need to be invested to restore a building to a certain state based on a state of assessed risk criteria. It does not include planned maintenance work (rather, it is work that should already have taken place)."

The latest figure is more than double the 2016/17 figure of £5.5m, and has **almost doubled in five years since** the 2018/19 total of £6.5bn: it reflects the chronic lack of capital to maintain, let alone expand or improve England's NHS after 13 miserable years of austerity funding.

And while around half (£3 billion) of the backlogs in 2018/19 were seen as 'high' or 'significant' risk, that proportion has now grown to 67% in the latest figures.

The Lowdown has calculated that **£3.9 billion** is classed as 'high risk,' which is defined as "where repairs/replacement must be addressed with **urgent priority in order to prevent catastrophic failure**, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution."

Trust	Total backlog £m
Imperial College Healthcare	769
Guy's and St Thomas	453
Nottingham University Hospitals	438
Airedale	353
Mid Cheshire Hospitals	340
Barts Healthcare	331
London North West Healthcare	302
Manchester University Hospitals	258
Oxford University Hospitals	240
Leeds Teaching Hospitals	205
University Hospitals Birmingham	198
Croydon Health Services	170
Buckinghamshire Healthcare	168
Royal Devon & Exeter Healthcare	164
East Kent Hospitals	160
Hillingdon Hospitals	153
Doncaster & Bassetlaw	151
Newcastle upon Tyne Hospitals	149
East Sussex Healthcare	148
Sheffield Teaching Hospitals	142
North Lincolnshire & Goole	142
Homerton Hospital	142
University Hospitals Southampton	128
Cambridge University Hospitals	125
University Hospitals Leicester	119
West Suffolk	113
Sandwell and West Birmingham	105
Queen Elizabeth Hospital Kings Lynn	105
Bedfordshire Hospitals	105
29 above £100m - total	**6,376**

Another **£3.9 billion** is in the next category, "significant risk," "where repairs/replacement require **priority management and expenditure in the short term** so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety."

Only a third of the total backlog is classified as moderate or low risk.

Four trusts now have "high risk" backlogs of **more than £100m**:

Worst hit is **Airedale FT**, one of the hospitals in need of rebuilding due to the use of defective "RAAC" ('reinforced autoclaved aerated concrete') concrete, with almost the **whole of the trust's £353m backlog** classed as "high risk"

Imperial in North West London, where almost half (£319m) of the £769m total backlog is high risk relating to the crumbling **St Mary's Hospital** (£145m) and the massive £174m maintenance backlog at **Charing Cross Hospital** (worsened by the 8 years of neglect while North West London health chiefs attempted to force through (subsequently abandoned) plans to close it down. Imperial also faces a £74m backlog at Hammersmith Hospital.

Sixty percent (£102m) of **Buckinghamshire Health Care's** £168m backlog bill is also "high risk" – most of this at **Wycombe General Hospital** (£84m)

And over 60% (£106m) of **Croydon's** £170m backlog is also high risk.

A number of trusts have inexplicably reduced their estimated backlog (**Hillingdon** Hospitals, for example reduced its bill from £236m in 2019-20 to £153m in the latest figures.

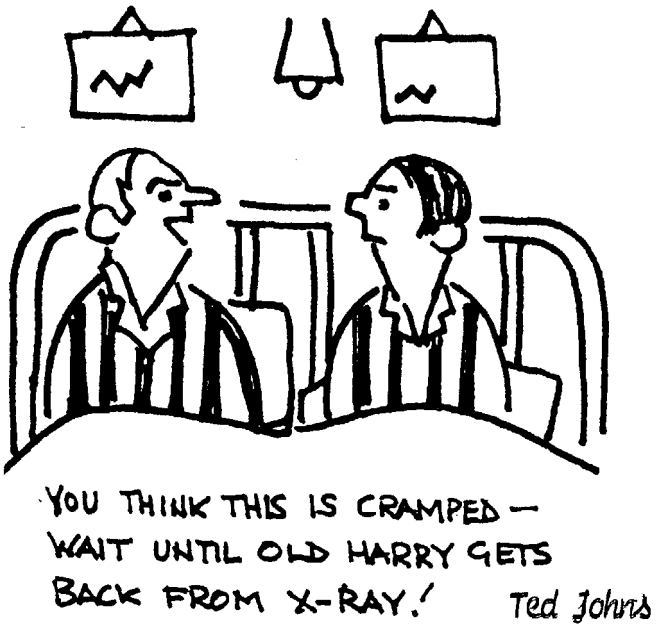
However **Nottingham University Hospitals** has seen a dramatic worsening in its state of repair, with its Queens Medical Centre now in need of £239m of repairs and upgrades, half (£121m) of which is either high or significant risk, out of a trust total backlog of £438m.

An ITV News report earlier this year revealed that nearly half of NHS hospitals in England have been forced to close wards and vital services due to flooding, power cuts and structural problems.

Click HERE to see the remainder of this article on The Lowdown website

IN THIS END OF YEAR 2023 SPECIAL ISSUE

No increased cash for NHS as winter sets in



John Lister

The latest emergency services data make grim reading: and the Royal College of Emergency Medicine (RCEM) is warning things are set to get even worse, after Jeremy Hunt's Autumn Statement came up with no extra cash to address the growing capacity gaps in the NHS.

The RCEM (doing work that really should be done by NHS England, NHS Providers and the NHS Confederation, which are supposed to speak up for the organisations they represent) had pressed hard in the run-up to the Autumn Statement for more funding to enable trusts to deliver on the promise last January of 5,000 extra beds (and 'most of' a promised 800 more ambulances on the road) this winter.

They got nothing.

The commitments to expand capacity were prominently included in NHS England's Delivery plan for recovering urgent and emergency care services, published with a fanfare in January.

The 5,000 beds promise was even repeated by the latest Health and Social Care Secretary Victoria Atkins on December 3.

But despite her warm words the tightening cash straitjacket on trusts and Integrated Care Boards have meant that ministers and health chiefs have not only failed to deliver many of the main commitments, but the **situation has actually got worse**.

The most recent statistics show that there were 100,046 general and acute beds available in England when the promise to open 5,000 more was made: but by October there were **2,675 FEWER beds**, even taking into account 2,224 "escalation" beds.

Rather than learning the lessons of last winter, the NHS is being forced to repeat the same mistakes again.

Indeed, as the BBC revealed back in April, far from putting **800 extra ambulances** on the road, most of the new vehicles actually ordered by ambulance trusts were routine replacements that had been delayed by previous spending constraints.

Just 51 additional ambulances were planned. And they will then be able to join the regular queues of ambulances outside over-crowded hospitals attempting to hand over emergency patients.

Same day

The Delivery Plan also promised "Same day emergency care services will be in place across every hospital with a major emergency department, so patients avoid unnecessary overnight stays."

But figures revealed by the HSJ show that around 40 out of 118 trusts that have been delivering 'same day' services are delivering a **smaller proportion of emergency care** in this way than they were a year ago.

There is also a wide variation in the level of same day activity, ranging from 60% of emergency department caseload in Maidstone and Tunbridge Wells to just 12% in London's University College Hospital.

While the England average is around 40% of emergency cases, there is a postcode lottery, with four London trusts (UCLH, North Middlesex, Epsom and St Helier, Croydon) delivering less than 20%, and 14 of the 118 trusts for which there any figures delivering less than 30%.

Several large providers had seen a **substantial drop in the proportion** of same day activity, including a 29% drop in Cambridge University Hospitals, a 31% drop in East and North Hertfordshire, a 40% drop in Frimley Health, and a 46% drop in Manchester University FT.

The HSJ report does not identify any possible reasons for the reduction, which is clearly not linked to lack of beds: but it seems likely that staff shortages and delays in accessing diagnostic imaging and other test results could explain the failure to progress one of the long list of NHS England priorities.

Staff shortages will not be helped by vicious new immigration regulations restricting the right of workers – even those coming to work in shortage occupations – to bring family members to live with them in Britain.

The new £38,700 minimum wage to qualify for family visas means that the new rules cover almost all the main pay bands of nursing staff.

Nine in ten

With the revelation that a staggering 93% of the 51,000 nurses recruited in the last four years have come from overseas, these new restrictions are likely to hit nursing as well as recruitment of vital social care staff.

The Delivery Plan in January also promised to "Speed up discharge from hospitals, to help reduce the numbers of beds occupied by patients ready

Other parts of the DHSC budget – including the education and training of health professionals – get no increase, and will FALL in real terms.

Mental health services are struggling to cope

Bad as the A&E figures are, they tell only the story of acute services, and leave out the growing problems and pressures on mental health services, especially since the Covid pandemic.

One snapshot of this comes from the revelation that the crisis-ridden Norfolk & Suffolk Foundation Trust has been sending patients as far afield as Newcastle, Bristol and Kent for treatment for lack of sufficient local beds while a key ward was renovated and then reopened with fewer beds for lack of staff.

The Birmingham and Solihull mental health trust has also faced severe problems including the deaths of three patients, and has now been told for a third time by the coroner to increase the numbers of beds.

And with official figures showing 24,000 children left waiting almost two years to be seen by community mental health services, it's clear the crisis is reaching intolerable levels in these services too.

to be discharged." Sadly here again, as winter sets in, the promise is yet to be delivered.

A new report from the King's Fund underlines the lack of any coherent structure or system of working to enable NHS and local government bodies to coordinate efforts and resources, despite the rhetoric about "integrated care." There were real problems in making effective use even where additional sums of money were suddenly announced at short notice.

The most recent figures on delayed discharge from hospital show fluctuations in numbers deemed to 'no longer meet the criteria to remain in hospital' and in numbers of these patients discharged day by day: but the numbers remaining in a hospital bed (around 12,000 per day), including the numbers who have been there over 3 weeks awaiting support from social care or community health services (around 6,000 per day) have remained largely constant.

Lack of beds

The lack of sufficient beds, limiting hospitals' capacity to treat both emergency and waiting list patients, is obviously a pressure on the most serious (Type 1) cases brought to A&E. **152,115** patients waited 12-hours or more from their time of arrival at A&E in October – this is equal to nearly **one in nine** (10.7%) patient attendances to major A&Es.

Worse still, 44,655 people (more than one in twelve of all emergency admissions) having to wait over 12 hours for a bed even after the decision to admit.

But it is also a problem for elective care, with September figures showing 15 trusts delivering less than 50% of treatment **within 18 weeks of referral**, against a target of 92%, with the worst performance from **Milton Keynes, at 38.1%**.

The other trusts in this bottom 15 are Countess of Chester; Stockport; Warrington and Halton; Manchester University FT; Liverpool Women's Hospital; East and North Hertfordshire; West Hertfordshire; James Paget Hospital; North West Anglia; United Lincolnshire Hospitals; University Hospitals Birmingham; University Hospitals Sussex; and York and Scarborough.)

Capital needed

NHS capacity is clearly inadequate to deal with the most pressing needs of patients: but it can only be expanded if there is an injection of additional capital and revenue.

It should not be left to the Royal College of Emergency Medicine to make this point to both the current government, and to their likely successors in the Labour Party.

They are riding high in the polls, but doubling down on their insistence that all that is needed to fix the NHS are "reforms" and that there will be no immediate increase in spending.

We can see where the current cash limits are dragging the NHS: sadly it seems another winter will take its toll on patients and hard-pressed staff without ministers or opposition leaders recognising the evidence staring them in the face.

New cash squeeze hits the ICBs

John Lister

The worsening financial plight of England's 42 Integrated Care Systems (ICSs) is widening the gulf between NHS England – issuing demands for further cutbacks to balance the books – and trusts struggling to make ends meet on the ground.

The situation has been worsened by the government (Treasury) refusal to allocate any additional money to the NHS to cover the extra costs of keeping services going during the repeated rounds of strike action, even though these were triggered and prolonged nationally by the government's own stubborn refusal to negotiate on NHS pay, especially junior doctors.

NHS England has now estimated these costs as totalling around £1 billion: and in the absence of additional funds, they have had to hold back efforts to reduce the 7.7 million-strong waiting list and further cut back already pared-down plans for digitisation in order to free up **£800 million** to allocate towards the costs of the strikes.

But with ICS deficits estimated as £1.5 billion worse than planned in the first six months of the financial year (and the plans already skewed by ridiculous assumptions of massive savings to balance the books in many ICSs), NHS England's new priorities until April are "to **achieve financial balance**, protect patient safety and prioritise emergency performance and capacity."

ICSs were given just **two weeks** to complete "a rapid exercise" to identify and agree ways to balance the books, with some telling the Health Service Journal this means setting out "unpalatable" options for cuts in spending, and another talking of "nuclear options" being discussed that would be "catastrophic for quality of care and/or nigh-on impossible to deliver."

The most recent Lowdown survey of Integrated Care Board (ICB) meeting papers showed the worsening situation, but also warned that few if any ICBs have actually spelled out how they and local providers intend to save the tens, or hundreds of millions needed to balance the books.

Giving these bodies just two weeks to agree on new plans ensures there could be minimal if any consultation or public debate on what is to be cut, by how much, and why.

Some have discussed the need for radical change in scary broad-brush terms, notably **Lancashire and South Cumbria ICB**, which needs to "save" £450m to bring its deficit down to £80m by April. Its chief executive has made no bones about his ambition to "reconfigure" hospital services – closing at least **half of the current six A&E units** and leaving just two or three elective sites, along with major non-clinical reconfiguration.

However none of this has yet come forward as detailed proposals.

We may now begin to see more tangible and dramatic proposals on how to make the spending cuts necessary to balance the books: but with just **four months** left to the end of the year, three of them the toughest months of the winter, only the most draconian measures could deliver the scale of cuts required.

Even now the further £350m of cutbacks NHS England has made to the Frontline Digitisation programme, coming on top of the £630m reduction announced in August, means the original £2.6bn scheme has been **slashed by 40% to £1.6bn**.

The website *digitalhealth.net* explains that the cutbacks mean that only the trusts in the very weakest position, those lacking any electronic patient records system, and those with only a business case but no functioning system, will now get any funding.

Another 132 trusts that had been promised funds to optimise or extent their EPR systems will get nothing.

Click HERE to see the remainder of this article on The Lowdown website

NHS bosses warn over lack of investment

John Lister

Both the bodies representing NHS and foundation trusts are increasingly warning of the dire consequences if there is no extra capital funding for England's NHS. The NHS Confed argues that NHS capital budgets need to **nearly double** from £7.7bn to £14.1bn – **an extra £6.4bn** in **all three years** of the next Spending Review – if the NHS is to clear the building repairs backlog and overhaul the estate to enable greater productivity and faster patient care.

It warns that capital budgets continue to be raided, "with the latest raid being used to plug the rising deficits in the day-to-day NHS budget caused by strike action and other cost pressures."

Matthew Taylor, chief executive of the NHS Confederation said:

"Some of our members have parts of their estate that are barely fit for the 19th century, let alone the 21st, so any future Secretary of State for Health and Social Care must make the physical and digital condition of the NHS a priority, if the health service is to reduce backlogs and get productivity levels to where the government want them to be."

The Confed's November 28 press release cites examples of the progress and cash savings that can be made from investment – and the setbacks that follow when there is no capital to invest in improved diagnostics, noting the cancellation of a £25m planned diagnostics centre in Bedfordshire, Luton and Milton Keynes.

It warns that not only does the government not have a capital strategy for the NHS, but that the UK has consistently spent less money on capital investment than comparable countries for more than half a century, resulting in healthcare productivity increasing at an average of 0.9 per cent annually over the past 25 years:

"In the ten years to 2019, Health Foundation analysis suggests that had England matched the EU14 OECD average for healthcare capital spending, **we would have spent another £33bn on capital**.

"Instead, we have leaking roofs, broken lifts and outdated IT systems waiting to be fixed …"

"It's not just acute services: the Confed argues that almost one in every six mental health and learning disability sites in England were built before 1948 and 20% of GP practice premises are not fit for purpose.

"So bad is the situation that "In one case up to 15% of staff time was wasted on estate problems, like putting buckets under leaky roofs, which could be spent on patient care."

Had England matched the EU14 OECD average for healthcare capital spending, we would have spent another £33bn on capital

While the Confed's urgent plea for action came too late to make any impact on Jeremy Hunt's tight-fisted budget that continued to starve public services of investment to hand out tax cuts, its rival NHS Providers got in earlier with a November 14 warning that trust chiefs believe this winter could be even tougher for the NHS than the last:

"Money worries continue to mount with more than three in four trust leaders (76%) saying they are set to be in a worse financial position than last year.

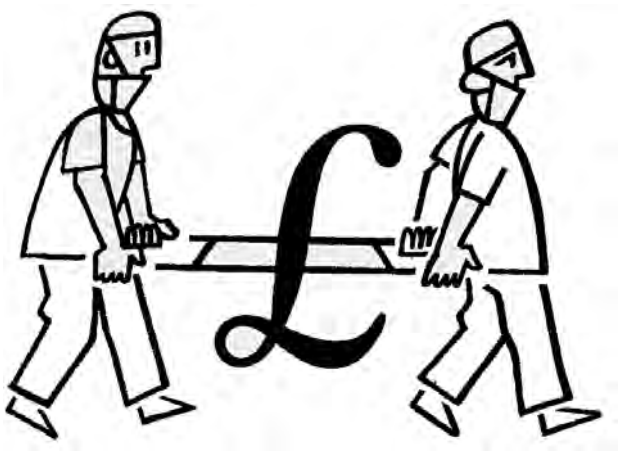
" Funding pressures are fuelling concerns about future patient safety and the quality of care as well as threatening to hit trusts' ability to ramp up services as they brace for winter."

Its survey of trust leaders found almost universal gloom:

- **Eight in 10** leaders (80%) say this winter will be tougher than last year (66% said last year was the most challenging they had ever seen).
- **95% are concerned** about the impact of winter pressures.
- **Most (78%) are worried** about having enough capacity to meet demand over the next 12 months – higher than before the pandemic in 2019 (61%).
- Most are concerned about the current level of burnout (84%) and morale (83%) in the workforce.
- **Almost nine in 10** (89%) are worried that not enough national investment is being made in social care in their local area.

Hunt, as we know and could have predicted, remained unmoved by the crisis created by 13 years of under-funding by a succession of Tory chancellors.

But as the Confed and NHS Providers warn, the cost of this will be felt by patients.



Abuse of migrant care workers is widespread, UNISON reports

Carers recruited from overseas are suffering appalling levels of exploitation, financial abuse and threats from unscrupulous employees, according to the Unison report – Expendable Labour.

Unison is now calling on the UK government and the Home Office to bring in measures to help safeguard against the shocking practices highlighted in the report, including

- a fully-funded minimum rate of pay above the national living wage for all care workers,
- recruitment only via agencies on the ethical recruiters list run by the NHS,
- dedicated funds to enable councils to clamp down on abuse, and ultimately:
- "a national care service to boost wages, put quality above profitmaking and ensure everyone receives the support they need."

Unison General secretary Christina McAnea noted:

"Workers from abroad have sold everything they own to come here and care for people. But instead of receiving decent pay and conditions, and being treated with dignity and respect, the UK government is letting employers get away with terrible practices that should be consigned to history."

"To top it off, ministers are demonising migrant workers by blaming them for all the country's woes. They're complicit in allowing the abuse to continue and in a raging culture war that's now targeting low paid migrant workers."

Social care

Social care has a major workforce crisis, with low pay and long hours making recruitment and retention of staff very difficult. People who would once have worked as care workers, now find better pay and conditions in hospitality and retail.

As a result employers are increasingly recruiting care workers from overseas including from India, the Philippines, Sri Lanka, and Zimbabwe. According to Skills for Care figures, international employees make up 16% of the social care workforce in England.

A change in immigration rules, after intense lobbying by the industry, led to the inclusion on the Shortage Occupation List and Health and Care worker visa route of senior care worker roles in April 2021, then after further lobbying, in February 2022 care workers were added to the list and visa route.

A working week of 80 hours or more has been reported by some migrant care workers. Others have been made to do 19-hour shifts without a break

The most recent Skills for Care report, covering the year from April 2022 to March 2023, showed a vacancy rate down to 9.9% from 10.6% the previous year (still around 152,000 vacancies on any given day, though), which was heralded as a positive. But the major driver of this reduction in vacancy rate is an increase in international recruitment, in particular from non-EU countries.

What the Unison report highlights is some of the appalling abuse of the migrant staff that are behind the improvement in vacancy rate figures.

The Expendable Labour report includes evidence of threats of dismissal and deportation, excessive hours (or no work at all), and racial abuse for these workers.

Even before they land here, these workers are exploited by recruitment agents, who demand excessive amounts of money. The result is that some migrant job-seekers sell everything they own to pay these 'relocation' costs.

Once here unscrupulous employees deduct money from their wages to cover "dubious" fees and are forced to pay extortionate rents for substandard accommodation.

Draconian clauses

Moving jobs is practically impossible as migrant workers are expected to sign contracts containing "draconian clauses," including a requirement to pay back recruitment and training costs if they leave their post within a few years. Unison has seen evidence from workers who have effectively been blackmailed into staying because their employers have threatened them with a large debt should they leave.

A working week of 80 hours or more has been reported by some migrant care workers. Others have been made to do 19-hour shifts without a break and forced to be always available for work.

Unison was told by a domiciliary care worker from India that: "Overseas staff miss out on enhanced payments for working weekends and bank holidays. We don't have regular schedules – we must be available as needed. Every conversation with the managers feels threatening and often ends with the word 'visa'."

Care work is dominated by private companies, many are small and financially unstable, and all are highly dependent on contracts from local councils. A change in contract can be financially disastrous for a company and staff will be made redundant in a particular area or the company will go bust.

If migrant workers are laid off due to lack of a contract or the company goes bust, they face the threat of deportation because there is no safety net to protect them financially or help to find a new employer.

Deportation threat

Under current rules staff who lose their jobs have 60 days to find a new employer and sponsor or face deportation. Unison is calling for this to be extended, saying the rule means companies can threaten workers with deportation if they try to leave.

The report's release coincides with a backlash by the right wing of the Conservative party against immigration due to the release of net migration figures. Immigration minister Robert Jenrick has announced plans to cap the numbers of visas for NHS and care work and prevent migrant workers bringing family members with them.

However, Christina McAnea notes: "The Government needs to reform immigration rules, not make them more draconian. Ministers' attention would be far better focused on fixing care and boosting pay so careers in the sector are more attractive. It's time to stop scapegoating migrants and instead give councils greater funding to tackle those exploiting them."

Ms McAnea told the Mirror: "Employers, left with no choice but to recruit foreign workers, are horrified at the Government's latest attempt to appease its right-wingers. Care staff, many of whom have sold all they own to come here, will be terrified at having to choose between their children when it's time to renew their visas. This terrible policy could well prove the final straw for the care sector."

Slightly amended and abridged from Lowdown original November 30.

Operose flogged off, complete with 60 GP practices

John Lister

The giant American health corporation Centene has now completed a divestment of all its health care investments in England by selling off its subsidiary Operose, which had controversially acquired 60 GP practices, mainly in London.

This marks the end of what the Financial Times saw as an attempt by Centene to open up a 'seamless pathway' potentially enabling Operose-run GPs to refer to its own chain of hospitals. When Operose was put up for sale The London Press, quoting Victor Chua of Mansfield Advisors, a healthcare consultancy, explained why the strategy had failed to deliver:

"Centene has found it difficult to make Operose profitable because many Operose sites are in generally less affluent areas where recruiting GPs has been difficult. There was no natural cross-sell between the

Operose GPs and the Circle Hospitals, which serve a different demographic, and the geographic overlaps are limited."

So Centene decided to pull out, and this latest sale follows Centene's sale in August of Circle Health Group, and with it Britain's largest chain of small private hospitals, which they had only purchased in 2021, to Emirates-based Pure Health.

Although Centene, once the American company most heavily invested in British health care, has now dumped all of its overseas investments to concentrate on extracting the maximum profits from its home base in the US, the hospitals and the GP practices it has walked away from in England have now been bought up by new investors – and they, too, will be seeking profits.

PureHealth which bought Circle is the largest healthcare platform in the Middle East and has a diverse portfolio "comprising more than 25 hospitals, 100 clinics, multiple diagnostic centres, health insurance solutions, pharmacies, health tech, and procurement."

The company has just made initial public offering (IPO) of 1.11 billion shares, representing 10 per cent of its share capital, with "robust interest on the first day." It plans to list its shares on the Abu Dhabi Securities Exchange (ADX) on December 20, and claims to be "on a strong growth trajectory."

PureHealth's "international acquisitions and ambitious plans" also include the recent purchase of Ardent Health Services, the "fourth largest private healthcare group in the USA". Whether its British investment in Circle delivers the required level of return is yet to be seen.

Now Operose has been sold, to HCRG Care Group, the company which took over Virgin Care at the end of 2021, raising questions over the future of the 60 Operose-owned GP practices.

Despite having lost some of the Virgin contracts it initially took over, HCRG has claimed to be running 21 GP practices, as well as urgent care services and community health services for the NHS.

However with this latest change of ownership many patients in Operose's London GP practices will have been bundled through three different profit-seeking companies since 2021.

There were loud protests and legal challenges in 2021 over the way practices, complete with their lists of patients, were simply taken over when Centene, via its UK subsidiary Operose Health Ltd, acquired AT Medics, which operated 49 GP surgeries across 19 London boroughs.

This time it may even be possible that one or more of London's five Integrated Care Boards that commission primary care might pluck up the courage to refuse to sign off on yet another sale. The Lowdown hears that Operose expects to continue as a going concern and continue running its GP practices, albeit with a change of parent company.

However they could face a rude awakening. HCRG is owned by venture capitalist group Twenty20 Capital, which boasts that it expects its investments to deliver "significant returns in 2 to 5 years".

What changes might be demanded to ensure its new GP practices deliver the required profit margins are yet to be seen.

Serious failings in homecare medicine services

Patients are coming to serious harm by a lack of regulation of the private companies in the homecare medicines sector, according to a damning report by the House of Lords Public Services Committee.

The failure of regulation, noted the Lords, means that:

"No one—not the Government, not NHS England, not patient groups, not regulators—knows how often, nor how seriously patients suffer harm from service failures in homecare."

Not only are patients being harmed, but the lack of transparency in contracts and procurement means nobody knows how much the companies are being paid, despite it being billions of pounds, which the Lords described as "shocking and entirely unacceptable."

Over half a million people with chronic conditions in England depend upon the delivery of medicines to their homes. These types of services known as 'homecare medicines services' often also include help in administering the medicine. They replace care that would previously have been supplied in hospital.

The main providers are private, for-profit, companies, with Sciensus, Healthnet Homecare, and Alcura, among the largest companies involved.

The Lords committee, named no individual company in its report, but addressed the entire sector noting:

"Some patients are experiencing delays, receiving the wrong medicine, or not being taught how to administer their medicine.

"Where this happens, it is no small inconvenience—it can have serious impacts on patients' health, sometimes requiring hospital care.

"This leaves NHS staff either firefighting the problems caused by problems in homecare medicine services, or working on the assumption that those services will fail."

In terms of payment the Lords noted that:

"In some cases, the taxpayer is effectively paying for the service twice – once for the private provider to deliver it, and again for the NHS to pick up the pieces where private providers fail."

The report noted failures across the board in the services: in transparency; procurement; enforcement of standards and regulation; and in infrastructure.

Estelle Morris, the chair of the committee, said: "The system has grown into a fractured and complex mess, with no one named individual or body having overall responsibility for defining and ensuring performance across the sector. It is not even possible, at the moment, to assess performance: no one is publishing any data."

"The regulators in this sector are weak. We saw a hands-off approach where no one regulator wanted to look too hard at performance and no one is in charge."

● This is a much shortened version of the original November 28 Lowdown article, the whole of which is available HERE

Still no boom in private health care despite record NHS waiting lists

The PHIN figures showing minimal growth

John Lister

The latest figures from the Private Healthcare Information Network (PHIN) make worrying reading for private hospital bosses, with no sign of the long-expected boost in numbers of patients dipping in to savings or borrowing money to pay up front for tests or operations to escape growing NHS waiting lists and delays.

Overall numbers of patients treated in private hospitals in 2019, prior to the Covid pandemic, averaged 195,000 per quarter.

In 2022, with England's NHS waiting lists having increased by almost 3 million, this average increased by just 7 percent (14,000), to 209,000 per quarter, peaking at 216,000 in Quarter 4.

The numbers are only a tiny fraction of the NHS patients facing long delays for treatment.

This year's figures show 228,000 admissions in Q1, dropping to 215,000 in Q2, up 6 percent to a higher average so far of 221,000 (13% higher than the level in 2019).

However all of this growth has come from treating less profitable patients covered by medical insurance, while self-pay numbers, after remaining largely static at around 70,000 per quarter since Q2 of 2021 fell back to just 67,000 in Q2 this year.

And because these are UK-wide figures it's worth noting that the statistics include a significant increase in self-pay admissions in Northern Ireland (up 90% from 1,000 to 1,900) and in Wales (up 17% to 4155), while numbers fell 2% in Scotland (80) and by 7% (4,100) in England.

This has left even PHIN to raise the awkward question "has self-pay reached its limits in England and Scotland?"

More insured patients

The private sector is concerned because the limited and falling numbers of self pay patients has run alongside more patients making claims on their private medical insurance.

In Q2 these numbers were "at the second highest level in PHIN records," with 12,000 more insured admissions than in the same period in 2022 (9% increase).

Private insurers here, as in the US, are ever eager to pull in new subscribers, but far from happy at having to fork out to cover claims, which limits profits: and they in turn try to screw down the fees charged by the private hospitals.

So doubts remain over the future growth of the private hospital sector, much of which is being effectively propped up by the numbers of NHS-funded patients that are being treated.

The PHIN report also shows a substantial 14% (2,700) drop in numbers of cataract operations in Q2 compared with the same quarter last year and a 20% (3,500) fall in numbers of admissions for chemotherapy, both of which are by far the most common treatments delivered.

When 'extra' NHS capacity is not really extra

Keen-eyed HSJ reporters have spotted evidence of a sharp uptick in trusts' use of outsourced (mainly "independent") providers in England at the end of the last financial year.

The figures are tucked away in NHS England's cumbersome quarterly reports, giving retrospective overall figures for spending by trusts on outsourcing, over and above the commissioning of outsourced contracts by England's 42 Integrated Care Boards.

At the end of 2023, NHS England's quarterly figures have just come in for the final quarter of 2022-23 (January to March 2023).

As the HSJ highlights, they show an increase to £4.7 billion in spending on work outsourced by trusts to non-NHS providers, a near-doubling of the £2.4bn spent in the same quarter of 2019-20, the last months before the Covid pandemic.

However adding up all the quarterly figures for both whole financial years reveals that there was only a fractional increase from £11.3bn in 2019/20 to £11.4bn in 2022/23.

The significant increases in Quarters 3 and 4 of the last financial year (2022/23) correspond with the increased pressure from government (and, sadly, from Labour politicians) for the NHS to make more use of private sector providers.

A year ago Rishi Sunak further cranked up the pressure on NHS commissioners and providers to help fill up otherwise empty private beds and clinics by establishing a top-level "task force," which we later learned was stuffed with private sector representatives.

Its plan, predictably, focused on increasing the short-term use of the private sector, while lacking any longer-term vision to ensure NHS capacity can be increased to meet the needs.

The National Joint Registry does indeed show numbers of hip replacements conducted in private hospitals have increasingly outnumbered those done within the NHS.

But their statistics also show a net overall reduction in numbers of joint replacements since the peak of Covid pressures eased, compared with 2019, and a further decline in 2023 compared with last year.

In other words, use of the private sector is not increasing the numbers treated, merely ensuring that more of the cash flows **out of the NHS into private pockets,** rather than becoming part of the revenue stream to sustain NHS services.

Extracted from Lowdown original December 19

MPs conclude that NHS workforce plan cannot deliver

By NHS Support Federation, November 10

The cross-party Public Accounts Committee has heavily criticised the government's 15 year workforce plan in a new report, in particular the lack of funding estimates and have "serious doubts" on how the plan will be achieved.

The committee notes that the "unfunded and uncosted" workforce plan, which promises to train thousands more GPs and double medical school places, risks placing the NHS under 'unsustainable financial pressure' in the future.

Dame Meg Hillier MP, chair of the committee, said: "The government and health system need to be alert to the serious doubts our report lays out around the workforce crisis, both the approach to tackling it now and the additional costs funding it in the future."

Published in June 2023 after many years of waiting, the NHS long-term workforce plan received a mixed reception; relief that a workforce plan had at last been published, but criticism of its lack of detail.

Funding

The BMA at the time noted the lack of detail in the plan on measures to retain staff, improve the culture and how exactly funding would be provided:

"As ever, the devil will be in the detail – especially when it comes to funding."

Details of how the plan will be funded and its full cost have failed to materialise.

The MPs highlighted that although an additional £2.4 billion is to be provided to cover training costs for the first five years of the 15-year plan, there is no estimate of total additional running costs for the 260,000 to 360,000 extra workers the plan says will be needed by 2036-37.

Although an additional £2.4bn is to be provided to cover training costs for the first 5 years of the 15-year plan, there is no estimate of additional running costs for the 260,000 to 360,000 extra workers the plan says will be needed

Detail is also missing on how productivity is to be improved; the workforce plan includes a projection for future staff requirements that assumes staff productivity will increase by 1.5% to 2% annually, but the committee noted that it "lacks meaningful detail on how this will be achieved."

Noting, "there is no information available on either the scale or source of how staff costs in future years will be met. Neither is there any cost or funding information on the other enablers without which the plan will fail for patients, such as expenditure on other salaries, estates, technology, and infrastructure."

As well as criticising the workforce plan, the MPs covered failings in urgent and emergency care and patient discharge, finding that "the quality of patients' access to urgent and emergency care depends too much on where they live."

In London in 2021-22 the average ambulance response time was 6 minutes 51 seconds, but in south-west England it was 10 minutes 20 seconds. Ambulances aim to respond to the most serious life-threatening injuries and illnesses in an average time of seven minutes.

Response times

Ambulance response times are often dependent on how quickly patients can be transferred into A&E, and this in turn is governed by availability of beds. The committee noted that not enough is being done to tackle the problem of delayed discharges, which mean beds are not available.

More patients are remaining in hospital when they no longer need to do so. In Q4 of 2022– 23, there was an increase of 12% in patients remaining in hospital despite no longer needing to, compared with the same period in 2021–22.

Lack of adequate social care is a major factor in delays, but the MPs also criticised NHS England for its slow implementation of electronic patient records and electronic bed management systems, noting that

"NHS England has identified where there is good practice and poor performance but is weak at implementing and rolling out best practice more widely."

In response to a report, Saffron Cordery, deputy chief executive of NHS Providers, said:

"The committee has highlighted accurately the huge pressures being faced in urgent and emergency care….

"The NHS needs more staff, beds and equipment and significant investment in social care….

"And with 125,000 unfilled jobs across the NHS today, MPs are right to highlight that we still don't know exactly how all of the ambitions in the long-term workforce plan, published in June, will be funded."

"the quality of patients' access to urgent and emergency care depends too much on where they live."

Community mental health services failing children and young people

BarnetUNISON Mental Health social worker strikers begin another 5 days of strike action on 15 January

ONE IN FIVE children and young people in England aged eight to 25 have a probable mental disorder, according to a new survey from NHS England, with large rises in the last few years in the number with eating disorders.

But years of underinvestment in community mental health services means these children and young people are struggling to get access to care, with NHS England data released for the first time showing that over 24,000 are waiting almost two years to receive any help.

This data exposes the shocking state of mental health services in England, which was called a 'national emergency' by health leaders back in October, who warned that the continued lack of resourcing for mental health has left services overwhelmed and at breaking point.

One in five

The Mental Health of Children and Young People in England 2023 report, published by NHS England, found that 20.3% of eight to 16-year-olds had a probable mental disorder in 2023, among 17 to 19-year-olds, the proportion was 23.3%, and in 20 to 25-year-olds it was 21.7%.

The survey, commissioned by NHS England, and carried out by the Office for National Statistics (ONS), the National Centre for Social Research (NatCen), and University of Cambridge and University of Exeter, is considered to be England's best data source for trends in children and young people's mental health and how this has changed since 2017.

The survey covers a range of topics, including bullying, substance use, self-harm and feelings about cost of living, education, climate change and the future.

In 2023, 12.5% of 17 to 19-year-olds had an eating disorder, up from just 0.8% in 2017. Between 2017 and 2023, rates rose both in young women (from 1.6% to 20.8%) and young men (from 0.0% to 5.1%) in this age group.

Eating disorders rose in 11 to 16-year-olds as well. In 2023 eating disorders were identified in 2.6% of this age group, compared with 0.5% in 2017 – with rates in 2023 four times higher in girls (4.3%) than boys (1.0%).

Although the prevalence of mental health disorders has risen, increases in investment and capacity in services has not kept pace. Recent data released by NHS England on waiting times for community mental health services shows a shockingly high number of children and young people having to wait almost two years before being seen.

HSJ analysis of this data puts the figure at more than 24,000 children and young people waiting almost two years to be seen. With 19,000 adults with a serious mental illness waiting for longer than 18 months for a second contact with community mental health services.

In total, almost 240,000 children and young people were waiting for treatment from community mental health services in August 2023, as well as more than 192,000 adults.

The lack of community mental health services means patients often turn up at A&E in crisis. Here they can wait hours (with some reports of waits of over 80 hours) until they are redirected to more suitable care options. In many cases patients are admitted into inappropriate acute hospital beds meant for physically ill patients. This then delays treatment for patients who need treatment for physical conditions.

One acute trust chief operating officer (COO) in the North of England said:

"We have weekly, often daily, instances where we have mental health patients in our ED awaiting mental health beds. These patients often wait three or more days in our ED."

Trusted sources from within the 'system' tell us that the NHS's regulators (NHS England, NHS Improvement and CQC) do not want to hear, indeed refuse to listen to, 'bad news' about NSFT

Matthew Taylor, chief executive of NHS Confederation said:

"The current focus on the elective recovery, industrial action and GP access has meant that mental health has slipped down the government's set of priorities and patients and services are being forgotten. This is a national emergency which is now having serious consequences across the board, not least for those patients in crisis."

Taylor added that although "urgent and increased targeted investment in community mental health teams" is needed, "many of the solutions to this problem lie outside of the NHS, not least with the need for more supported housing and social care support."

Council spending cut

Unfortunately, local government has seen its spending power fall steadily since 2009/10, with the amount of money authorities have to spend from government grants, council tax and business rates in 2021/22 now 10.2% below 2009/10 level.

Data compiled by Unison, the trade union, published in September 2023 found councils are facing a record cash shortfall of more than £3.5bn with more cuts to jobs and services being considered by councils.

Such is the worsening situation in mental health social work teams, with high waiting times for patients, worsening practice and chronic staffing issues, that UNISON staff in community mental health services in Barnet, have been taking strike action since October, with more planned in January.

Barnet UNISON branch secretary John Burgess says: "The waiting lists are extraordinarily high and all the experienced staff have left or are leaving.

"It's not safe for staff and it's not safe for service users, because if you don't build relationships with social workers, how is that meant to be therapeutic?"

Health inequalities continue for people with learning difficulties or autism

By Sylvia Davidson

People with learning difficulties and those with autism are not receiving the same standard of healthcare as the general population leading to shorter lives and many more avoidable deaths, according to data from recent studies.

The annual Learning Disability Mortality Review (LeDeR), published at the end of November, found that people with learning difficulties in the UK live shorter lives and the chances of their deaths being classed as 'avoidable' is almost double that of the general population.

The LeDeR found that of the 2,054 adults with a learning disability who died in 2022 and had a completed recorded underlying cause of death, 853 (42%) had their deaths classified as avoidable.

Avoidable deaths

Although this was lower than the 2021 figure of 50% of avoidable deaths among adults with a learning disability, it remains "significantly higher" than the percentage for the general population across the UK, which was 22.8% in 2020, the latest data available.

The authors of the LeDeR report said: "We believe that things may not be improving fast enough, and overall care and outcomes all too often still fall below acceptable standards compared to the general population."

Academics at Kingston University with researchers from King's College London and the University of Central Lancashire compiled the report as part of the NHS England and NHS Improvement-funded LeDeR programme to improve healthcare for people with a learning disability and autism, reduce health inequalities and prevent early deaths.

The LeDeR report also reveals concerning trends in the number of people with learning disabilities who die during heatwaves, as well as disparities among ethnic minority

groups and those living in the most deprived areas.

Professor Irene Tuffrey-Wijne, leader of the Staying Alive and Well co-production group that helped with the report and a Professor of Intellectual Disability and Palliative Care at Kingston University said:

"It is good to see that risks of premature death can decrease with good levels of care and reasonable adjustments, but we cannot sugar-coat the stark truth that people with learning disabilities still die several decades earlier than the general population, and that many of these deaths are avoidable."

Dan Scorer, Head of Policy and Public Affairs at Mencap noted:

"Whilst the report shows evidence of an increase in life expectancy for women with a learning disability, they are still dying 23 years earlier than women in the general population.

" In addition, with deaths of people with a learning disability living in the most deprived areas at 3 times the level of those living in the least deprived areas, there's no room for complacency."

He added that urgent action is needed to address the fact that people from Black, Asian and minority ethnic backgrounds are at a much-increased risk of experiencing health inequality and premature death.

The most commonly reported underlying causes of death were related to diseases of the circulatory, respiratory or nervous systems.

The biggest life expectancy gap was seen between autistic women with a learning disability and the general population, with this group, on average, living until just 69.6 years old

The report recommended prevention and better management of avoidable and long-term conditions in adults, particularly among 25 to 49-year-olds, improved management of specific long-term and recurrent conditions, and addressing reasons for increased risk of avoidable death in males compared with females.

The report also noted "a concerning effect on excess deaths of people with a learning disability during heatwaves, which may become more frequent in the future due to global warming."

For the first time, this latest LeDeR report investigated deaths of autistic adults without a learning disability, due to concerns that autistic people may also experience health inequalities that could lead to avoidable deaths. The number of reviews included, however, was small at just 36 and the authors noted that "only limited conclusions can be made".

The authors described inclusion of data for autistic people as a separate group for the first time as "a step towards improving information and data collection on the causes of death for autistic people in England".

The importance of including such data in the LeDeR report is backed up by two studies also published in November that focus on autistic people and health inequalities.

A study published in The Lancet Regional Health – Europe, of thousands of autistic people with and without a learning disability found that they have a reduced life expectancy compared to the general population.

This study is the first to estimate the life expectancy and years of life lost by autistic people living in the UK.

Anonymised data

The researchers, led by those at University College London, used anonymised data from GP practices across the UK to study people who received an autism diagnosis between 1989 and 2019.

In total, 23,580 people were included in the study. Of these, 17,130 people had a diagnosis of autism but not a learning disability, while 6,450 participants had a diagnosis of both autism and a learning disability.

The biggest life expectancy gap was seen between autistic women with a learning disability and the general population, with this group, on average, living until just 69.6 years old. The average life expectancy for women is 83 years old. That's 13 years less life. For an autistic male with a learning disability death is,

on average, eight years earlier than the general population.

The researchers found that autistic men die, on average, five years earlier than non-autistic men, and autistic women die six years younger.

The lead investigator of the study, Professor Josh Stott, said: "Autism itself does not, to our knowledge, directly reduce life expectancy, but we know that autistic people experience health inequalities, meaning that they often don't get the support and help that they need when they need it."

Lancet study

A study published in The Lancet Psychiatry, also in November, specifically looked at the help autistic people get from mental healthcare services and found that autistic adults that use NHS mental healthcare services are more likely to experience worse therapy outcomes compared to non-autistic people.

NHS mental healthcare services recommended for anxiety and/or depression are the talking therapies, cognitive behavioural therapy (CBT) and counselling. The study used existing data from large medical records databases to measure participants' outcomes (depression and anxiety scores) both before and after therapy to see if there was an improvement in symptoms.

They found that autistic people were 25% less likely to see an improvement in symptoms of anxiety and depression compared to non-autistic people. They were also 34% more likely to experience a deterioration in these symptoms.

Depression

The study also found that despite experiencing much higher levels of depression and anxiety than the general population, autistic people are largely under-represented in mental healthcare services.

The authors suspect that this is due to the "specific barriers" that autistic people experience to accessing therapy and the lack of appropriate adaption for neurodiversity. This includes differences in thinking style, sensory sensitivities or the need for predictability.

The National Autistic Society (NAS) says this study reflects what they hear all too often: "That autistic adults are not getting the mental health support that they need."

Anoushka Pattenden, Evidence and Research Manager (Partnerships) at NAS, said: "Action needs to be taken now to make sure health services are just as effective for autistic people.

"It's vital that mental health professionals receive training in identifying and understanding autism, are flexible in their approach, and include autistic people in discussions about the treatment and adjustments they need."

Much needed changes and improvements in the way autistic people are treated within the health system received a major setback, however, when the government dropped reform of the Mental Health Act from the King's Speech at the beginning of November. This was despite knowing the contents of a four-year long enquiry led by Baroness Hollins, condemning the government's failure to end the "inhumane treatment" of autistic people and people with learning disabilities.

Tim Nicholls, Head of Influencing and Research at the National Autistic Society, said:

"The King's Speech was a vital opportunity for the Government to commit to reforming the outdated Mental Health Act, and address the ongoing crisis of autistic people being stuck in mental health hospitals. The Government has failed to keep its promises."

NHS dentistry – where did it all go wrong

By Ollie Jupes (the pseudonym of a retired NHS dental practitioner)

In 2006 the Labour Government introduced a new contract for contracted health service dental practitioners. Other than from hospital or community-based dentists, all NHS dental work is carried out by independent contractors who are responsible for providing their own buildings, equipment, materials and staff.

Before the introduction of the 'new' draconian system, NHS dentists had been working under a long-established 'fee-per-item' system where practitioners had been paid per filling or per extraction or crown.

Even that system was underfunded. A single-surface (simple) filling attracted a fee of £6.80 at a time when the overheads of many dental practices (at that time) ran at roughly £60 per hour per surgery.

In those days, if I was carrying out a filling on an adult molar in a youngster – especially for the first time – there was no way that I could complete the task in anything less than half-an-hour without a lot of gentle persuasion and a few tears (mainly mine).

You don't have to be Professor Brian Cox to work out that at that sort of pay rate, it's going to be a struggle to pay your overheads – but at least with the old system, if you provided two fillings, you were paid for two.

The introduction of the dental contract in 2006 meant that patients with high needs – for example, someone who hadn't attended for many years and presented with many gum problems and numerous decayed teeth which needed fillings, gum treatment and/or extraction – had to be treated by the dentist at the same payment scale as a regular attender who needed only one filling.

I personally ended up, on one occasion, treating a patient with a dozen fillings and a couple of extractions for about £60 in total, earned over a number of appointments and about three hours work.

The new contract brought with it a new term – a Unity of Dental Activity (or UDA as it's more commonly known) which was an arbitrary unit plucked out of the air and bore no resemblance to the work that actually goes on in a dental surgery.

For example, a simple one-surface filling was given the same UDA value as a complex molar root-filling, which can on average take up to two hours to complete. With the rise in dental litigation and complaints made against dentists in the UK, it is no wonder that many dentists are now refusing to carry out challenging and complex work like root-fillings, preferring to refer to specialists, who operate, of course, privately.

This is a much truncated extraction from a longer Lowdown piece HERE

UnitedHealth – the company at the heart of US healthcare

John Lister

American health giant UnitedHealth made occasional unsuccessful forays into primary care in the 2000s, and more recently its Optum subsidiary has been picking up lucrative contracts for NHS support services including IT, number-crunching and back-office systems.

But so far it has shown little sign of any more serious effort to invade much more of the under-funded English health care system, least of all as an insurer. This is in stark contrast to UnitedHealth's burgeoning expansion in the US, where, despite only minimal involvement in direct patient care, it has grown close to creating a "private single payer system."

A detailed article published in August by The American Prospect magazine, Health Care's Intertwined Colossus, explores the prolific growth and the scope of UnitedHealth's powers in the US market, and helps explain why its bosses might regard England as offering comparatively slim pickings.

The article shows how the corporation's growth has been intrinsically linked to the US system, where extensive lobbying and donations to both major parties has enabled the health care corporations to buy the connivance of US politicians at national and state-wide levels.

Profits from non-profits

UnitedHealth began in the 1970s as a for-profit company managing a non-profit business in Minneapolis, and it has grown by utilising all of the loopholes and contradictions of the world's most expensive and dysfunctional health care system, to become the fifth largest public company in the US, and one of the 30 largest in the world.

While it's best known as an insurance company, UnitedHealth began as a health management company but

has extended its tentacles of power in many more directions, becoming the largest employer of physicians in the US, but also buying up pharmacies, primary care clinics, surgical and urgent care centres, home health providers, mental health providers, hospices, an IT division, and more.

UnitedHealth bank

United has even set up its own bank, offering among other things pay day loans (at 35 percent interest) to independent physicians … waiting for payment of their invoices to UnitedHealth.

Its story began with the Nixon government's encouragement of 'health maintenance organisations' (HMOs) as an alternative to fee for service.

HMOs offered a reduced fee to patients, but limited their cover to hospitals and doctors they employed or contracted directly with: the decision-making in health care was increasingly handled by accountants and insurers rather than by doctors.

By the early 1980s United's founder Richard Burke had spotted the additional profit stream to be made from managing the drugs available to HMO subscribers, and established the first Pharmacy Benefit Management company, which began to coin in profits … at the expense of higher prices for patients as more costly brand names were favoured over cheaper generics.

United began to acquire HMOs and other health insurers, and use its growing market power to force down prices from doctors and hospitals and undercut rival insurers.

While the growth of HMOs was good for business, the 1990s saw increasing anger at the ways they could be seen denying patients treatment and giving doctors incentives to limit treatment. Nonetheless they became the only game in town: between 1989 and 1996 annual HMO transactions grew from $1 million to $13 billion.

Attempts to rein in the powers of the HMOs proved fruitless, even when 700,000 physicians joined forces in a class action suit against United and other HMOs in 2002, alleging fraud and racketeering.

Tax deductible

George W Bush's government created Health Savings Accounts (HSAs), allowing wealthier people to save in tax deductible funds against the risk of requiring health care – and United spotted the profitable opportunity to establish a bank offering HSAs, and is now the second largest in the field, holding £20 billion from millions of users.

The authors show how time and again UnitedHealth has been the first, most ruthless and most brazen in exploiting every opening;

- cornering 80% of the market in claims data management;
- buying up an "independent" think tank to influence government policies;
- pocketing billions in government subsidies for health information technology and electronic health records systems;
- and even cashing in on the Obama administration's effort to increase the "Medical Loss Ratio" – forcing health insurers to spend as much as 80-85% of their premium revenue on patient care. (United's response was to further expand, so that more premium income could pile up more profit.)

More recently United's emphasis has been on buying up groups of physicians, making them employees, but doing so one at a time to avoid scrutiny from regulators. The more physician practices they own, the more United can force down physician fees – and eliminate any competition.

Paying up

Time and again when caught in the wrong by the courts, United has paid sums as high as $890 million to settle cases. But the company has also been able to ride through other legal challenges, with compliant judges happy to nod through the most ruthless conduct as consistent with the free market values of the US.

The result has been poorer care and higher costs for patients: according to the Kaiser Family Foundation in June, United denies almost a quarter of all claims for treatment by independent doctors.

It's become a beast too big for the US government or its weak-kneed regulators to tame or contain, and too powerful for its rivals to challenge. UnitedHealth Group gross profit for the quarter ending September 30, 2023 was $23.4 billion, a 17.22% increase year-over-year.

This is the first section of a longer Lowdown article which can be viewed HERE

New NHS deal "too generous to big pharma" say campaigners

By John Lister

Concerns over the privatisation of health services tend to be focused on the outsourcing of elective clinical care, mental health, diagnostics, support services and data management.

The staggering (and still rising) £19.2 billion annual bill for pharmaceuticals in England (2022/23) is often overlooked, even though it has increasingly been reported as a key factor in the deficits faced by trusts and Integrated Care Systems.

Almost three quarters of this spending (£14bn; 73%) is on branded drugs, which carry the highest mark-up for the drug companies, even though there is a yearly cap on the total sales value of branded medicines.

Now ministers have been criticised by campaigners for a new 5-year deal, signed this month, that the government claims will "save the NHS £14 billion over 5 years," while in fact the level of annual growth in sales of branded drugs will double from 2% in 2024 to 4% by 2027.

Ministers also boast that the agreement includes a commitment by the pharmaceutical industry to "invest £400 million over 5 years" – just £80m per year – to support work on clinical trials, manufacturing and "innovative health technology assessments."

Caving in

In response, Global Justice Now, which has taken the lead in campaigning to rein in the profiteering by Big Pharma, accuses ministers of caving in to the drug companies, with a deal that is far too generous. Tim Bierley, pharmaceuticals campaign manager at Global Justice Now said:

"… this deal effectively doubles the cap on sales growth of branded drugs. It's hard to see how the NHS won't be spending far more on drugs than previously, making this deal too generous to big pharma."

The latest government press release speaks of more than "65 years of working together" with the drug industry to "help manage the affordability of medicines for the NHS." But in July Bierley and GJN were flagging up the massive profits from the NHS in the last ten years, estimating that £12 billion of excess profits were derived from just 10 drugs – each of which had been developed with support from public funds or charities.

The GJN figures only highlight profits over and above a "reasonable 50% profit margin" above estimated production and distribution costs.

23,000% mark-up

But the average underestimates some much more extreme examples, such as one company (Bristol Myers Squibb BMS) charging a mark-up of 23,000% on a key cancer drug, lenalidomide (Revlimid), despite having contributed extremely little to its development.

Nick Dearden, Director of Global Justice Now, said: "Currently, money we need to keep the NHS going is being poured into pockets of wealthy shareholders of big drug corporations."

Sonia Adesara, NHS doctor and campaigner, said: "This research shows that the prices pharmaceutical companies charge the NHS have little to do with the cost of producing medicines.

"The markup on these 10 drugs alone is enough money to cover pay restoration for junior doctors. Instead of battling with health workers who are struggling to keep up with the cost of living, the government should be trying to claw back the rip-off prices charged by pharmaceutical companies."

BMS's monopoly on production of lenalidomide, and the consequent inflated price, has since been broken with a number of companies offering generic versions at much lower cost: the limited time during which the drug companies have the opportunity to generate these super-profits from their monopoly position on new drugs is another factor forcing the prices ever higher.

In November GJN led a coalition of campaigns and MPs from the SNP, Greens and Labour parties in writing to new Health Secretary Victoria Atkins to warn against capitulation to "pharma lobbying," noting that the drug companies had been pressing for "new rules which would force the NHS to pay an extra £2.5 billion a year to access medicines".

Open letter

The letter, backed by organisations including Keep Our NHS Public, We Own It, the People's Health Movement, Just Treatment and STOPAIDS, pointed out that far from investing increased revenues in research and development of new drugs, "most pharma companies spend more on share buy backs, or on selling, general and administrative activities, than they do on research and development." It goes on:

"Even more worryingly, pharmaceutical companies are already drifting away from investing in truly innovative drugs, with over 50% of new drugs that reach the market failing to represent a therapeutic advance for patients."

When new, useful drugs have been developed recently it has most often been by, or with support from the public sector, although the end product is then sold by the drug corporations at inflated prices.

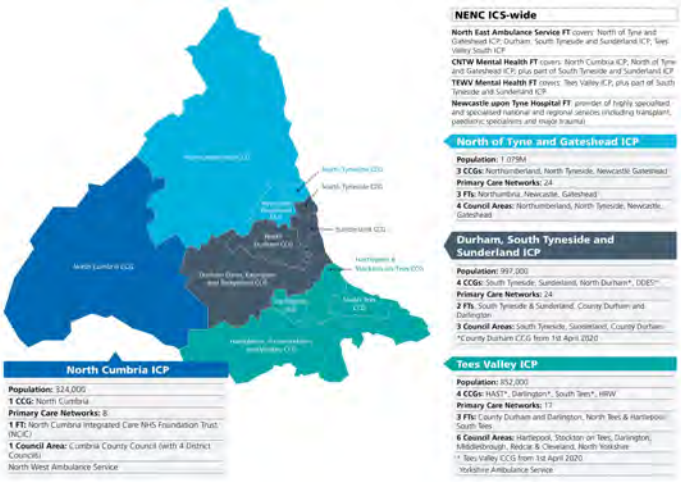
An October press release by the Peoples Vaccine campaign underlined the scale of the rip-off by Big Pharma, which grew to monstrous proportions during and since the Covid-19 pandemic. It sums up:

"More than $1 million was paid to [pharma] shareholders and executives every 5 minutes during COVID-19 pandemic."

The biggest life expectancy gap was seen between autistic women with a learning disability and the general population, with this group, on average, living until just 69.6 years old

Read the remainder of this article HERE

North East campaigners fight to open up ICBs and decision-making



John Lister

Campaigners struggling to follow decision-making and policy proposals in the giant North East and North Cumbria Integrated Care System (NENC ICS) have written to the principal NHS leaders in the area to express their concerns at the loss of local democratic accountability since July 2022, when 42 "Integrated Care Systems" took over responsibility for health commissioning across England.

They are keen to see their challenge to the current set-up publicised, and where possible echoed, by local campaigners up against massive obstacles to democratic accountability in other areas of England.

In the north, within the NENC ICS there are three levels of operation and decision-making:

The **Integrated Care Board** is the body that takes decisions over commissioning and but also sets budgets and targets for providers (NHS trusts and GP services) and must work with local government across the whole of the ICS area, coast to coast (the largest ICS in England)

Sub-divided

The ICS is sub-divided into four **Integrated Care Partnerships** (ICPs) – North, Central, South and North Cumbria. ICPs are jointly convened by Local Authorities and the NHS, comprised of a 'broad alliance' of organisations and other representatives, which are supposed to work as "equal partners concerned with improving the health, public health and social care services provided to their population."

The four NENC ICPs meet independently in their localities. There is also a 'Strategic Integrated Care Partnership' meeting and Board, which is made up of reps from the four areas – this Strategic ICP meets twice per year.

Each of the four ICPs are further sub-divided into **place-based teams**. These follow 14 local authority boundaries and the previous CCG areas.

However none of this has been properly opened up to the public in the north of England (or in many other areas).

So Keep Our NHS Public North East, Save South Tyneside Hospital Campaign and KONP Sunderland joined forces on November 25 to forward a jointly-written open letter to NENC ICB which focuses on openness, transparency and collaboration regarding decision-making at local sub-committees and Board meetings.

Reduction in democracy

All three North East Campaign groups are increasingly concerned by the obstacles to public access and involvement, the reduction in local democracy and restricted access to papers and information that have made it harder to hold NHS bodies to account under the new system.

The letter notes the limited involvement of elected councillors on the ICB Board, "and a very real danger that local voices will not be heard at the ICB at this top level." It argues that that more could be co-opted.

It goes on to highlight the inaccessible location of most ICB meetings, at a venue on an industrial estate 2.5 miles away from Durham city centre.

"Given the huge geographical footprint of the ICS, we recommend some consideration be given to arranging a more accessible location, ideally near a transport interchange served by train, bus, metro and with nearby parking. … a location (for example) by Newcastle Central Station would seem to be a more obviously accessible choice."

Another problem is the restrictive requirement that any **questions to the Board** must be based on the agenda – and therefore cannot be prepared before the agenda is published – or point out where issues have not been properly discussed.

And since questions must be received three working days before the Board meeting is held, the late publication of agendas makes this almost impossible: only **one** of the last six NENC ICB agendas was published with even the minimal three days before the meeting. With the ICB only meeting every 2 months, and questions relegated to the very end of the agenda this arrangement gives little or no chance to question the Board. The campaigners urge the ICB to offer an option to ask a question in person, and a right to reply.

No public access

There is an option for the **Integrated Care Partnership** meetings to be held in public. However that is simply a form of words. In practice:

"Currently, the ICP Area meetings are **not held in public** and there is **no public access to the agenda, minutes or reports**. There is, thus, no process in place for a member of the public to put a question directly to the Area ICP meeting relating to healthcare provision in their own region."

On **place-based teams** the situation is even worse: "The specific activity of the local place-based teams **remains unknown to the public**.

"The ICS has stated that "the place-based subcommittees are not meetings held in public," but claims minutes from these meetings go to the ICB's Executive Committee monthly "for assurance purposes."

But for place-based decision making to be in any way accountable, the campaigners argue, the **minutes of the place-based sub-committees** should be in the public domain. Decisions on commissioning and procurement – the future of our healthcare – are being made within the place-based and ICP teams, and this needs to be transparent.

Without these changes to the way it conducts itself, there is no way the stated commitment of the ICS to "put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS" and to "build understanding and trust" can be delivered.

It's likely that similar problems are being encountered in many if not all of the 42 ICBs, and it's only by publicly raising these issues that NHS bosses can be shamed into making the simple changes that would at least offer a degree of accountability and allow campaigners and the wider public to keep up to date with changes and plans that affect the health care of whole communities.

It's conspicuous that in this challenge Healthwatch, which is supposedly the local body to represent the needs and views of the wider public, are having to be treated in the same way as the senior management, and urged to stand up for a more democratic approach.

The full text of the letter is available at https://konpnortheast.com/ics/ (scroll to part 7).

Labour will not "turn on the spending tap"

John Lister

Keir Starmer and Shadow Health secretary Wes Streeting want to play it both ways. On the one hand Labour has been posting on social media claiming: "The longer the Tories are in power, the longer patients will wait. Only Labour has a plan to cut NHS waiting lists and get patients treated on time again."

Of course no serious plan exists: the promise to cut waiting lists hangs on a wing and a prayer, with a a large side order of wishful thinking and lashings of down-right delusion.

That's because at the same time as this empty promise is made, a totally contrary message is being conveyed by Starmer and by Streeting in news studios, articles and interviews in the right wing press, insisting that – if elected – a Labour government will certainly "not turn on the spending taps."

This even implies, as the *Financial Times* concludes, that Labour might feel obliged to contemplate **further cuts** in public services – while of course blaming the situation on the economic mess that will left behind when the Tories eventually lose office.

Promises to right wing

Starmer and Streeting to keep promising the right wing of the Tory electorate that there will be no increases in taxes (even on the super-rich and windfall profits in the energy companies) and no increases in spending.

If they stick to that promise, Labour can't offer even a glimmer of light at the end of the tunnel for 1.4 million hard-pressed NHS staff.

The NHS workforce have to cope as best they can with crumbling hospitals (backlog maintenance bill now £11.6 billion), clapped out equipment, 120,000 vacant posts, too few beds, and gaps in social care, community health services and overstretched GP services. This winter, deficit-laden hospital trusts are also facing impossible demands for yet more "efficiency savings," with some managers warning "nuclear service cuts" are needed to balance the books.

To make matters worse Streeting, with his private sector donors to keep happy, and effectively echoing Rishi Sunak, also keeps calling for the NHS to make more use of private providers, while giving no evidence to show how this would improve matters.

"Lessons"

He has also been taunting NHS leaders, arguing they should "learn lessons" he has drawn from the superficial impressions he has gained from his recent tour of Australia, accompanied by the paywalled hard right *Telegraph's* health editor Laura Donnelly.

She duly served up adoring articles trumpeting Streeting's nonsense, not least the ridiculous claim that "Australia has the answer to fixing the NHS … spending less but achieving more."

Anyone who bothers to check OECD spending figures knows Australia **doesn't spend less**: it spent **17% more** per capita than UK in 2022 (equivalent to an extra £27 billion this year for the NHS).

Older population

Nor is there any direct comparison between the two populations: the UK has a much higher proportion of older people (21% more aged **65+** per 1,000 people, 23% more **80+**).

And Australia's health system is notoriously complex and wasteful, with hefty government subsidies for private health insurance, money which experts argue could be "more cost-effectively invested in other programs, such as public hospitals and chronic disease prevention in primary care."

Streeting clearly doesn't understand the NHS, or the systems he is visiting: and even where he has seen some potentially relevant ideas, **not one** of the 'innovations' he is now touting from Australia or Singapore could be implemented in England's NHS without more spending.

Starmer and his shadow cabinet already seem to be showing the same fundamentalist zeal to boost private provision as Tony Blair's government displayed in the mid 2000s.

Conservative

But team Starmer are **much more conservative** on public spending than New Labour were in 1997, when they insisted on sticking within Tory spending limits for three miserable years.

Only in 2000 did Blair announce the historic decision that the UK's health spending would be increased over a decade, to raise it closer to the average of comparable European countries.

Had that funding not been invested the NHS would almost certainly have virtually collapsed on a number of fronts.

Now, after 13 years of austerity and real terms cuts in funding since New Labour lost office in 2010, the NHS is already in a much worse state than it was in 1997. A Starmer government won't have three years to tread water and postpone the necessary investment.

Every additional contract for private providers will only worsen the plight of NHS providers … while lining private sector pockets. Nor will Streeting be able to deliver any of his fancy ideas for primary care without spending more: instead the shortages of GPs and gaps and delays in services will only get worse.

NHS staff, battered and bruised by successive Tory governments, are desperate to see Labour's leaders commit to positive changes and investment to enable them once again to deliver speedy, safe, high quality services as they did back in 2010, rather than face a continual decline.

Needing hope

Patients too, and the wider public need some hope that things might change for the better in our most popular public service. Many of them need persuading that Labour does offer a genuine alternative rather than the same old arguments we hear each day from Rishi Sunak's ministers. Promising none of the resources needed for change may please the Tory right, but it will dismay all of Labour's natural supporters.

Once again the real danger is that even if they do get elected – if **there is no change of line** – a Starmer government could preside over a real collapse of the NHS that was established by Clement Attlee's far from leftist government 75 years ago. And nobody will forgive them for that.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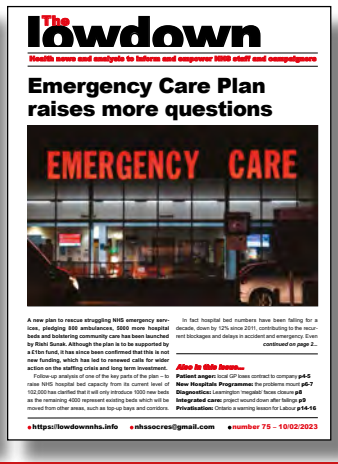
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