THE lowdown

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

Fifth time around! Election pledge recycles old promise of more GPs

Weary GPs have heard it all before – FIVE TIMES!

The Conservative Party has once again pledged to increase recruitment of GPs, and to create "50 million more GP appointments a year".

This time the promise is for **6,000** new doctors to general practice by 2024/25, **half of them** fully qualified GPs along with **3,000 trainees**, who would be spending longer training in general practice that they do currently.

Round 1 2015

The problem is that this is a variation of the same old promise that has been wheeled out time and again with ever-diminishing credibility since 2015 when Jeremy Hunt first promised 5,000 extra full time equivalent (FTE) GPs by 2020. That was four years ago, during the election campaign.

By the end of June 2015 Hunt was already "softening" his promise and admitting it was the highest achievable increase. But three months later he was at it again, promising an extra 5,000 GPs by 2021.

Round 2 2016

Recruiting an extra 5,000 GPs from home and abroad was also set out as an objective early in 2016 by NHS England in the GP Forward View.

Round 3 2017

Early in 2017 Hunt made the job of GPs even more onerous and unattractive by requiring them to record patients' migration status. He also claimed that the purported £500m extra revenue from charging overseas patients for treatment could help pay for the anticipated 5,000 extra GPs (see inside page X).

Neither the revenue nor the GPs have materialised.

By May 2017 even the King's Fund was questioning the credibility of Hunt's promise, pointing out: "In 2016, there were 34,495 full-time equivalent GPs (including locum doctors).

"Rather than an increase, this represented a fall of 96 GPs, or 0.3 per cent of the GP workforce, compared with the previous year."

"The losses again highlight the spectacular failure of the Government's pledge to hire 5,000 extra GPs between by 2020."

***Daily Mail*, August 2019**

Round 4 2018

In June 2018 official workforce figures revealed that the NHS had actually lost 1,000 GPs since September 2015, when Hunt first pledged at least 10,000 extra primary care staff, including 5,000 GPs, within five years. GP magazine *Pulse* revealed NHS England's campaign to recruit GPs from overseas had signed up just 85 doctors.

Hunt confessed that he was 'struggling to deliver', admitting that 'it has been harder than we thought'.

By October 2018 Matt Hancock, Hunt's successor as Health Secretary, had abandoned the 2021 deadline, but reiterated the commitment to increase GP numbers by 5,000: **by then the FTE GP workforce had sunk to more than 1,400 below the level when Hunt's target was set.**

In November Hancock was embarrassingly forced to delete claims of a "terrific" increase of 1,000 GPs joining the NHS in just three months, after being **censured by the government statistics watchdog the UKSA**. Hancock was counting trainees as GPs: numbers of qualified GPs had had actually fallen by 674 over 12 months.

Round 5 2019

By August even the *Daily Mail* was pointing to the scale of failure:

"The NHS has lost almost 600 GPs in the last year as its recruitment crisis continues, figures show. "Almost as many family doctors left the health service between June 2018 and June 2019 as did in the entire three years to March. …

"The losses again highlight the spectacular failure of the Government's pledge to hire 5,000 extra GPs between by 2020."

Now in November a similar promise is being made again. Would anyone bet on this being delivered?

IN THIS FIRST PRE-ELECTION ISSUE

Don't hold your breath waiting for all £130m of repairs to be done

Hospitals crumble as ministers rattle out empty promises

John Lister

NHS Providers, the body representing trusts, has been campaigning for sustained increases capital funding for several years. Their CEO Chris Hopson argues that: "Over the last five years we've had to transfer nearly £5bn [of capital funding] to prop up day to day spending.

"As a result, the NHS now has a maintenance backlog of £6bn, £3bn of it safety critical. The NHS estate is crumbling and the new NHS long term plan can't be delivered because we don't have the modern equipment the NHS needs."

Warning

An NHS Providers briefing document in August warned:

"The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year)."

Our Lowdown table (left) draws on the recently published 2018-19 Estates Return Information Collection (Eric) statistics from NHS England. These show some of the latest figures on the scale of bills for backlog maintenance facing trusts around the country.

We have listed the trusts with combined bills of over £20m: they add up to almost £5 billion.

Most of these trusts are not on any government list for extra funding, and are set to receive no support as their buildings fall apart and equipment fails. The Conservative Party conference announcement equates to around £600m extra a year, well short of the additional £2bn that experts and health trusts say is needed. And £2.7 billion to build new hospitals will affect at most six trusts – leaving the others to cope as best they can.

The backlog total of £6.6 billion is 60% higher than it was five years ago.

Over half the backlog is to address 'high' and 'significant' risk, which has increased from 34% of the total in 2013 to 53% last year.

Between 2017/18 and 2018/19 there was a 25% increase in clinical service incidents arising from estates and infrastructure failure.

The results of a freedom of information request to all hospital trusts in England by the Labour Party in July 2019 revealed at least 76 hospital trusts in England suffered incidents caused by "estates and infrastructure failures" in 2018/19.

Many involved sewage, including sewage coming through the floor on the ultrasound corridor of one trust in Yorkshire and the Humber. Other incidents included leaks of wastewater and water into hospital wards, sewage coming up through the bathroom drains, broken lifts, inadequate heating systems, water running down walls and broken scanners.

In July 2019 fire chiefs threatened to close down parts of four hospitals as they were so rundown they had become a hazard to patients and staff.

Theatres

The recent scandalous state of operating theatres in Oxford University Hospitals Trust's once prestigious John Radcliffe Hospital underlines the scale and impact of this neglect. The Care Quality Commission has taken urgent enforcement action.

According to the Health Foundation the capital budget for hospital infrastructure has fallen in real terms over the last eight years, with NHS trusts in England seeing a 21% reduction in capital funding.

In 2010/11, capital spending by the DHSC was £5.8 billion, but by 2017/18 this had fallen in real terms to £5.3 billion, a fall of 7%. Joshua Kraindler, economics analyst at the Health Foundation, warns that:

"The capital budget is, in real terms, the same as it was in 2010-11 and as a result, capital investment per NHS worker continues to fall."

Trust	Combined backlog deficit (£m)
Imperial College Healthcare	691.1
London North West Healthcare	216.5
Barts Health	199.6
Oxford University Hospitals FT	140.5
Nottingham University Hospitals FT	130.7
Sheffield Teaching Hospitals FT	127.6
Pennine Acute Hospitals	124.5
University Hospitals Birmingham FT	118.0
Newcastle upon Tyne Hospitals FT	114.8
Leeds Teaching Hospitals	109.1
Hillingdon Hospitals FT	107.4
Cambridge University Hospitals FT	103.9
St Georges University Hospitals FT	99.2
East Sussex Healthcare	96.9
Epsom & St Helier University Hospitals	96.1
Sandwell and West Birmingham	91.7
University Hospitals of Leicester	88.6
United Lincolnshire Hospitals	82.9
Hull and East Yorkshire Hospitals	81.0
Doncaster & Bassetlaw TH FT	73.6
Calderdale and Huddersfield FT	73.1
Hampshire Hospitals FT	72.8
Buckinghamshre Healthcare	71.4
East Kent Hospitals University FT	69.3
West Hertfordshire Hospitals	68.5
University Hospitals Morcambe Bay FT	68.2
University Hospital Southampton FT	67.0
Medway FT	62.6
Gloucestershire Hospitals FT	59.0
Shrewsbury & Telford Hospital	57.8
Mid Yorkshire Hospitals	56.9
Manchester University FT	51.7
Mid Cheshire Hospitals FT	49.0
Royal Liverpool & Broadgreen	48.5
Princess Alexandra Hospital	48.4
Royal Berkshire FT	48.3
Birmingham Women & Children's FT	47.7
Royal Free London FT	47.5
South London & Maudsley FT	46.1
Royal United Hospitals Bath FT	44.8
Stockport FT	42.7
University Hospitals Plymouth	42.0
Salisbury FT	41.3
Kettering General Hospital FT	40.7
King's College Hospital FT	39.9
North Tees and Hartlepool FT	39.9
Poole Hospital FT	36.5
Wirral University Teaching Hospital FT	36.3
Lewisham & Greenwich	36.2
Northumbria Healthcare FT	35.4
Kingston Hospital FT	35.3
Lancashire Teaching Hospitals FT	35.1
Luton & Dunstable UH FT	33.9
Torbay and S Devon Health Care FT	33.4
Great Ormond St Hospital FT	33.1
Royal Cornwall Hospitals	32.4
Croydon Health Services	31.5
Taunton & Somerset FT	29.1
South West London & St Georges	28.8
Aintree University Hospital FT	28.4
Northampton General Hospital	28.3
East and North Hertfordshire	25.3
West Suffolk FT	25.0
University Hospitals Bristol FT	23.5
Bolton FT	23.2
Salford Royal FT	22.1
Walsall Healthcare	21.2
Airedale FT	20.0
Total (68 trusts above £20m backlog)	**4,952.80**

Trusts bid to gag NHS staff

Boris Johnson may be keen to be photographed with NHS staff – but he doesn't want to hear their concerns.

In fact the GMB union warns NHS bosses are trying to 'gag' staff during the general election.

A letter has been sent to workers from Ambulance and NHS Trusts across the country warning NHS employees they must not take part in "debates, activities and events that may be politically controversial."

Rachel Harrison, GMB National Officer, said:

"Our health service is at breaking point thanks to years of Tory mistreatment. Now staff are being told they can't talk about it in case it's politically sensitive.

"They must be allowed to be heard."

Government's "half price visa" scam won't solve staffing crisis

After repeated scandals in which overseas doctors have faced deportation or been blocked from entering the country by Home Office visa blunders, ministers have combined to shoot themselves in the foot with their latest proposal to fractionally lower the barriers to overseas staff coming to work in the NHS.

Their plans for a new "NHS visa" aimed at making it quicker, easier and cheaper for foreign professionals to take NHS jobs in the UK have been roundly ridiculed and condemned as "immoral" and "heartless" by the Royal College of Nursing, and branded as a new "nurse tax" by the LibDems.

The new visas, which appear to be opposed by NHS employers, are part of a new 'points-based immigration system' which will form an updated "hostile environment" if the Conservatives are re-elected.

Overseas health professionals would be guaranteed decision within two weeks – one week faster than the present system.

But while the costs of making an application would be 'halved' from £928 to £464, any staff coming to Britain would face the 'health immigration surcharge' of £400 a year: **so the total cost is not halved, but cut by a third.**

And as a triumphant expression of short-sighted thinking the visa and charges would also be extended to EU nurses (currently exempt) when the UK leaves the European Union.

Matt Hancock, claimed the new visa would make it "easier for us to hire the finest doctors and nurses from other nations to come and work in the NHS".

But of course it would be easiest if potential recruits did not face racist fees and charges at all.

Wilfully misleading:

Claims of £33.9bn extra spending inflate value by 65%

John Lister

Every year since the NHS was founded spending has gone up in cash terms to cope with rising costs and population.

So technically EVERY year has been the "highest-ever".

But the issue that matters to the NHS is the value of the money – what can it buy in staff and services?

If spending is falling behind inflation and cost pressures – as it has each year since 2010 – to simply quote the cash value is wilfully deceptive.

Back in the summer of 2018, to mark the 70th birthday of the NHS, Theresa May announced that funding for the NHS in England would be increased by £20.5 billion in real terms by 2024 – an average of 3.4% per year.

The cash increase to follow this up was formally announced in last November's budget, and the extra funding begins this year.

The budget allocation includes an amount to allow for inflation, and an extra £1.25bn each year for specific pensions pressures. That's why the total appears to increase by £34bn, rather than £20.5bn – from £115bn this year to £149bn in 2023-24.

This is the misleading higher figure Johnson and ministers are now trumpeting.

But the Philip Hammond's Budget statement made clear what is was worth (Table 1.7): "In June, this government committed to a new multi-year funding plan for the NHS in England, equating to £20.5 billion more a year in real terms by 2023-24".

The Health Foundation damned the increased funding with faint praise, arguing that the money would merely "help stem further decline in the health service".

The Institute for Fiscal Studies described the planned increases in health spending as "modest in the context of easily the tightest decade for the NHS since its founding."

The Health Foundation and other critics have also pointed out that increases of at least 4% a year on average are needed in order to meet the NHS's needs and see any improvement in its services.

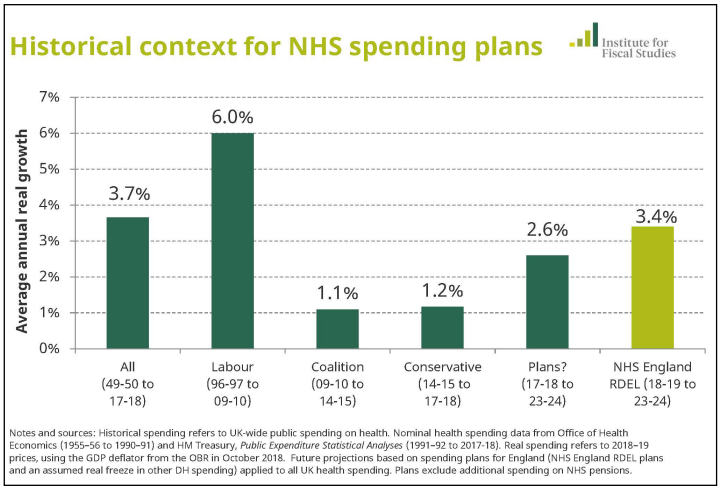
Anita Charlesworth of the Health Foundation earlier this year echoed the same view: "Healthcare funding has grown by an average of 2 per cent a year since 2010…. less than the overall rise in public spending, and below the estimated increases needed to address the lack of investment in staff and public health over recent years."

The £20.5bn increase also only applies to the part of the health budget controlled by NHS England. So other parts of the Department of Health and Social Care budget – including the education and training of doctors, nurses and health professionals and the public health grant income to councils for sexual health and children's services – get no increase, and will FALL in real terms.

In other words the accurate figure for the planned spending rise over five years is £20.5 billion – or less if inflation rises – in real terms.

By claiming it is '£33.9 billion extra' ministers are exaggerating its real value … by 65%.

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



Checking up on Johnson's fake forty new hospitals

The breathless press releases and media statements at the end of September spelled out a clear message, which some Tory candidates are now reiterating in the election campaign:

"Prime Minister Boris Johnson said: 'We're providing additional funding for 40 new hospitals to be built over the next decade.'

"Health Secretary Matt Hancock said: 'I love the NHS and I'm incredibly excited to be able to launch the largest hospital building plan in a generation, with 40 new hospitals across the country.'

It's hard to understand from this over-egged hyperbole that all the Johnson government has done is provide £2.7 billion to fund just **SIX** new or refurbished hospital projects.

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

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

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

None of the six new hospitals that have been given the "immediate" go-ahead is ready to start work for many months yet.

In **South West London** management of the **Epsom & St Helier** trust have decided the debate is about where to build a new £400 million "major acute" hospital. They will have to run a full public consultation, followed by a full business case. This story could run and run.

No quick relief for Whipps Cross

In **North East London** there will be a similarly long wrangle over the funding and size of a new hospital to replace the ageing **Whipps Cross Hospital**. The discussion has not yet even clarified where on the extensive Whipps Cross site the new building should be located.

In **Leeds,** the **Teaching Hospitals Trust** has been given the green light to build new hospitals for adults and children on the **Leeds General Infirmary** site, but the Trust board is far from ready to begin work at once: the project includes 'sympathetic redevelopment' of the Grade I listed Gilbert Scott Building.

In **Watford,** where **West Hertfordshire Hospital Trust** bosses have been "thrilled" by the funding to build a replacement, there is also an unresolved argument over the location of an acute hospital to serve the catchment area of almost 500,000 people. The Trust has promised to share their proposals "as soon as possible".

In **Harlow**, the **Princess Alexandra Hospital Trust** is free to build the long-awaited and interminably-discussed new hospital: management were "thrilled" but warned that there will be some delay before anything actually happens.

In **Leicester,** a 'pre-consultation business case', reputed to be a staggering 1800 pages long has been kept carefully under wraps. Before any new building can commence the Trust needs to brace itself for a full public consultation on reducing from three sites to two, and construct a viable Business Case.

Call for action to avert "corridor care"

John Lister

The President of the Royal College of Emergency Medicine, Dr Katherine Henderson, has urged hospital boards to take immediate action to reduce crowding in Emergency Departments this winter.

Dr Henderson said: "As the declaration of a critical incident at Nottingham University Hospitals Trust shows, winter has clearly arrived after minimal let up over the summer.

"Most departments are struggling to admit patients into hospital beds, and offload ambulances. The result is that sick and elderly and frail people are spending hours waiting on trolleys in a noisy, undignified environment.

"We are calling on hospital Boards take to take action. There must be a focus on creating capacity within the hospital to get sick patients out of the Emergency Department once they are ready to be admitted; long waits in emergency departments are associated with increased mortality."

4,000 more beds

Less than two weeks earlier the RCEM warned that the NHS needed at least 4,000 extra acute beds in England to avoid "corridor care", keep bed occupancy at a safe level, and keep emergency departments moving, between 4,000 and 6,000 staffed beds will be needed.

Dr Henderson said: "Since Quarter 1 of 2010/11 we have lost over 15,000 beds from the system.

"Performance against the four-hour standard at large A&Es was just 77% last month and declining performance is linked to declining bed numbers."

"Cuts to the bed base must be reversed otherwise we will end up seeing more patients stranded for hours on trolleys in crowded corridors.

"Bed occupancy during winter last year was an average of 93.5% - far higher than the recommended safe level of 85%. This was despite a mild winter, with the lowest number of bed closures due to norovirus in years.

"Performance against the four-hour standard at large A&Es was just 77% last month and declining performance is linked to declining bed numbers.

"This is bad for patients and demoralising for hardworking staff."

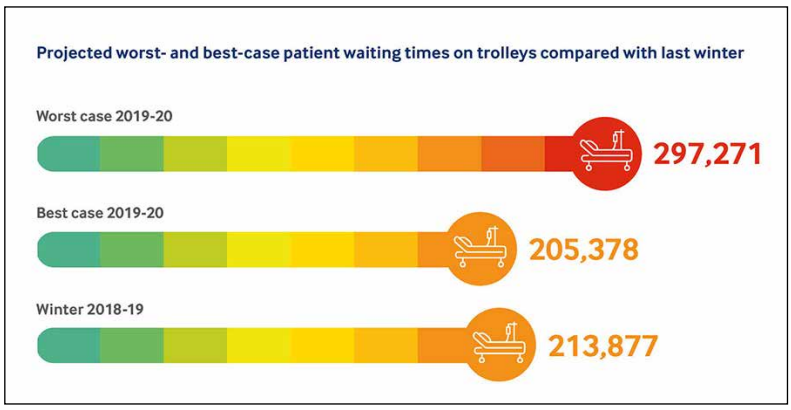
The calculation of 4,000 beds is based on the number of beds required to move to 85% bed occupancy.

However the RCEM has not calculated the numbers of consultant, junior doctor and nursing staff that would be required to allow these extra beds to be used.

With the vast majority of major NHS trusts already deep in deficit, seeking to cut spending and reliant on borrowing the funds to prop up flagging balance sheets, the cost is also a factor.

■ **The RCEM has announced that its 2019/20 Winter Flow will publish weekly aggregated performance figures from 50 trusts and boards across the UK, including the number of patients waiting 12 hours, or experiencing 'corridor care'.**

Embarrassing NHS figures postponed till after polling day



John Lister

Routine publication of the first Combined Performance and SitRep data that will show the gathering winter crisis in the NHS has been deftly postponed by NHS England to the DAY AFTER the election.

The statistics would normally be published on the second Thursday of the month – in this case polling day December 12. NHS England Statistics has now confirmed that the figures will appear on December 13.

This will be a considerable relief to the Johnson government, whose ministers would not have relished having to fend off critical questions on news media on the day voters will be making up their minds which party to support.

It's already clear that this winter is set to be yet another worst-ever for the NHS: the first hospitals have already begun declaring "black alerts" – now known as Opel 4 – in early November, and the winter's first "critical incident" was declared by Nottingham University Hospitals Trust – which has been exempt from normal reporting on its A&E performance since April because it is a pilot site trialling new targets.

All these indicators – along with the widespread record levels of bed occupancy and pressure on emergency services right through the previously relatively quiet summer months – are signs of impending crisis, and indicators that the numbers of beds and staff are insufficient.

Even before the first signs of winter the Nottingham trust's Integrated Performance report was a sea of red ink for missed targets for reducing delayed ambulance handovers, for patients marooned in beds for more than 3 weeks, for cancelled operations and for swift access to cancer treatment.

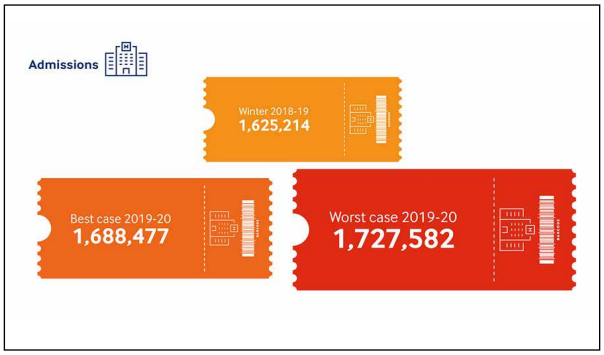
Trust finance directors are trying to wrestle down a projected deficit of £45m this year to £27m to qualify for a handout from the Financial Recovery Fund.

But the trust's finances are already propped up by £97m of borrowing, and the trust's buildings are saddled with a £130m backlog bill for maintenance.

The *Health Service Journal* notes that NUH also reported black alerts over the summer – "unusual for hospitals outside areas attracting high numbers of tourists" – and to make matters worse its urgent and emergency services were rated "requires improvement" by the Care Quality Commission in March.

Spread of 'Black alerts'

Early November has also seen black alerts at Queen Elizabeth and Lewisham Hospitals in SE London, both of which were full to capacity – but managed to avoid turning patients away, partly through the efforts of social care staff assisting to move some adult patients out of hospital more quickly.



"At the time of writing, the Government has not made any additional winter funding available to the NHS and social care to mitigate winter pressures, and with Parliament dissolved, there is now no mechanism to do so."

In Lincolnshire, where the United Lincolnshire Hospitals Trust is in its third year of special measures, the A&E is under pressure and management seeking measures including cancellation of non-urgent operations to free up beds.

Birmingham, too, is being warned to brace for a waiting times "nightmare" this winter, on the basis of analysis by the local newspaper's Reach Data Unit, which forecasts that in this one city hospitals could leave as many as 77,000 people waiting in A&E between January and March, with as few as 57.6% seen in the 4 hour target time.

Even in September only 64% of patients attending major A&Es in University Hospitals Birmingham Trust waited less than 4 hours, and the neighbouring Sandwell and West Birmingham trust was only slightly better at 67%.

BMA report

The Reach Data Unit applied the same methodology as a recent BMA report The NHS and a perfect storm of winter pressures, which warns that England's health service, trusts and GP practices are almost certain to endure "the most pressurised winter on record":

"Lack of recovery from summer, combined with other factors such as pensions taxation legislation forcing senior doctors to work fewer shifts to avoid large tax bills, and energy being spent on Brexit planning rather than winter preparedness, means the NHS is facing a 'perfect storm' this winter"

This last summer was worse than the BMA had expected, with actual performance worse than the worst case on A&E waiting times and trolley waits, with 179,000 waiting over 4 hours for a bed after a decision to admit.

The new report anticipates further increases in admissions and trolley waits, and warns "the winter could be substantially worse than our worst-case projections, especially if other factors – such as particularly cold weather and significant flu outbreaks – occur this year."

No winter funding

Perhaps most telling of all as voters are bombarded with professions of love for the NHS by government ministers is the lack of any additional funding to help services cope this winter:

"At the time of writing, the Government has not made any additional winter funding available to the NHS and social care to mitigate winter pressures, and with Parliament dissolved, there is now no mechanism to do so.

"In recent years, funding in the region of two to three hundred million pounds has been announced ahead of the winter months, but this year the NHS will receive nothing."

Beware unrealistic cancer promises as services are overrun

Paul Evans

Cancer services attract bold election promises as politicians know what the public wants to hear, but how many of these pledges can really be delivered?

The government have set a goal to save 55,000 lives a year through early detection of cancer and improved treatments, first announced by Theresa May and relaunched it in the new 10-year plan for the NHS.

In reality the NHS is so over worked that the existing government target for patients to start cancer treatment within 62 days of a GP visit has not been met for over three years.

Before the election campaign Boris Johnson's government announced a £200m investment in NHS diagnostics to upgrade and replace older mammography and diagnostic imaging equipment.

Welcome but insufficient was the conclusion of health economists, declaring that the new money is 'below what is needed to bring the UK up to an acceptable level'.

Falling behind

International comparisons show how far the NHS has fallen behind on basic capacity - in staffing and equipment.

Among EU15 and G7 countries, the UK currently has the lowest number of both CT and MRI scanners per capita, according to the Health foundation, with less than a third of that in Germany. They calculate that bringing the UK up to the average number of scanners would require around £1.5bn in extra capital spending.

Cancer UK remind us of size of the challenge – reporting that every year around 115,000 cancer patients in England are diagnosed too late to have the best chance at survival.

The weight of evidence says that identifying cancer early provides a much better chance of successful treatment, but progress with some cancers has been slower – for lung cancer almost half of people in the UK (48%) are diagnosed when their cancer is already at an advanced stage.

Cancer Research UK blame the government for not making progress in raising capacity, pointing to the critical areas like diagnosis where 1 in 10 of these NHS posts are currently unfilled.

"there's no plan to increase the number of NHS staff to cope with demand now or the growing numbers in the future" says Emma Greenwood, Cancer Research UK's director of policy."

NHS England published its interim NHS workforce plan in June, but this was not backed with any significant money to fund new education and training places.

Government pledges:

"We will save 55,000 lives through better cancer detection"

"I want to see the way we fight cancer in the NHS transformed, so we can confront this cruel disease with the best facilities to give our family, friends and colleagues the greatest chance."

Matt Hancock, health secretary

"For 41 months in a row the target for the time it takes people to start cancer treatment following an urgent referral from their GP has been breached. It has been the worst financial year on record (2018/19) for cancer waiting times with almost 34,000 people waiting too long for treatment"

Dr Moira Fraser-Pearce, Director of Policy and Campaigns at Macmillan Cancer Support

Unrealistic promises?

Last year the government pledged to catch 75% of stage 1 and 11 cancers by 2028.

It would require a big step up in activity – diagnosing an extra 100,000 patients early each year, but how realistic is this when currently cancer services are struggling to tread water?

Hospitals are continuing to miss their targets to start treatment quickly according to the latest NHS data for cancer waiting times.

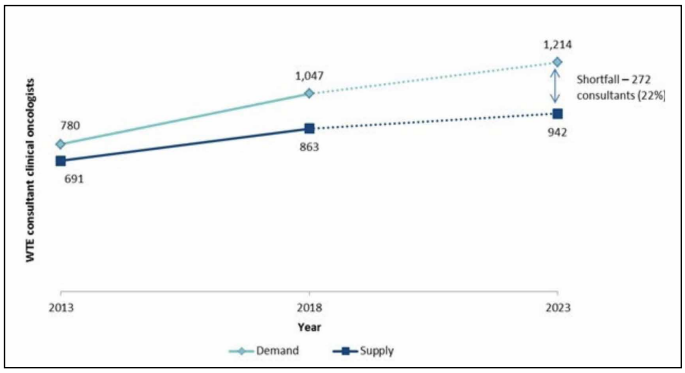
The current commitment is a maximum wait of 62 days from the time of referral by a GP: in fact nearly a quarter of patients wait longer.

Only 38% of NHS trusts meet the 62-day waiting times standard for referral to treatment for cancer patients.

A dossier of evidence collected by the Hospital Consultants and Specialists Association (HCSA) confirms the problems with understaffing.

A consultant radiologist reported that "Scan report turnaround time has gone from one week to over a month. "Unexpected and critical findings are going unreported for weeks. We are now just firefighting."

The HCSA state that delays of five to six weeks for scans are common and that patients are turning up to outpatient appointments but having to leave without their results



The growing shortfall of cancer specialists

because scans are not available.

A new study from the UK Lung Cancer Coalition (UKLCC), confirmed that there aren't enough scanners or staff to operate them, "putting the NHS far behind other European countries, including France, Germany and Spain."

In the UK, there are only seven radiologists per 100,000 people, which is "significantly below" the EU average of 12, the report said.

Understaffed

The Clinical Oncology UK Workforce Census Report 2018, warned that the workforce in clinical oncology is 18% understaffed and says that the UK needs to train double the number of oncology trainees to close the gap, but even then the gap would not be closed until 2029.

The NHS has fewer of nearly all types of staff than its counterparts overseas, relative to the number of patients.

Despite record under funding and a shortage of over 100,000 staff across the NHS is working much harder.

The number of patients referred for elective care has increased by 17% since 2013-14 and the number of patients referred for suspected cancer has almost doubled since 2010-11.

In the face of huge understaffing the NHS long-term plan, launched at the start of the year included a list of steps to improve cancer survival.

It emphasises earlier diagnosis, and sets out plans to "lower the threshold of referral".

However the NHS cannot expect to achieve the best cancer survival rates in Europe, or even to work in a safe and sustainable way until it solves its basic capacity problem – more staff and beds are needed in both hospital and community settings.

Health secretary's GP claim is misleading, but he can't hide the crisis

Paul Evans

At the end of August health secretary Matt Hancock loudly proclaimed a rise in the number of GPs, but was soon reminded this is contrary to official figures, which chart a clear decline in the number of family doctors over the last year.

"There's hundreds more GPs… we're moving in the right direction", said Hancock in a video posted on Twitter.

Statistics from NHS digital show that the number of full-time equivalent GPs has fallen by 576 over the past year, from 28,833 in June 2018 to 28,257 in June 2019.

Hancock's claim appears to be based on the total headcount of GPs which has increased by 2.7% but many of these doctors are part-time. The numbers could also have been inflated by a rise in the number of trainees.

The standard way to compare is to count the number of full-time equivalent staff and using this measure the fall in GP numbers in the last year is clear.

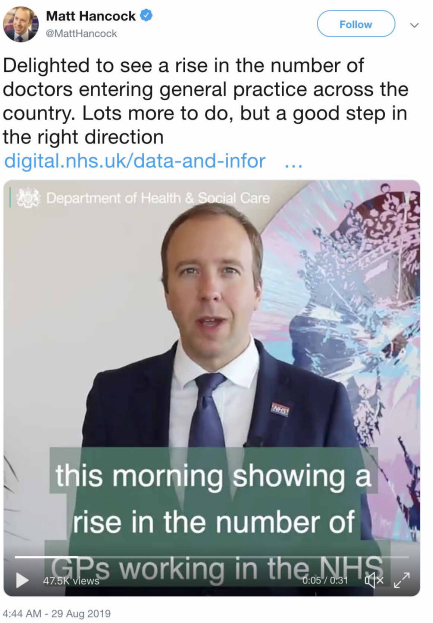
Overworked

The reality according to recent research is that GPs are dangerously overworked. Half of GPs are working beyond safe limits, on average completing 11-hour days and dealing with a third more patients than they should be.

The *Pulse* survey also discovered that, on average, each GP dealt with 41 patients per day. 10% say they deal with 60 or more patients a day, when evidence from European research shows that 25 consultations in a day should be considered a safe limit.

The long-term trend is no better, the number of GPs has fallen by 1300 since 2015, whilst the number of patients has risen by 1.4m, increasing the number of patients per GP by 8%.

All this explains why many of us are finding it hard to get a GP appointment. One in five patients now has to wait at least 15 days to see a GP in England, NHS figures have revealed.



The Conservatives have ramped up expectations with an election promise to recruit 6000 new GPs, but as we report in this issue (front page), this comes after years of failed attempts to meet a target of 5000 extra.

This year new GP training places have been filled, but the tough working conditions are driving existing GPs to retire or switch to other jobs.

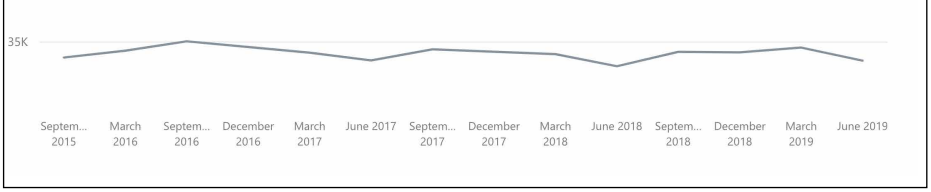
Research by Warwick University found that that over 40% intend to leave general practice within the next five years, an increase of nearly a third since 2014.

It takes at least 10 years to train a family doctor from entering medical school, so for the situation to improve more existing GPs must be encouraged to stay in the profession.

'There is a point where I feel cognitively drained; after about 20 patients, there is not an iota of empathy left.'

– An overworked Hertfordshire GP

GP numbers 2015-19 (England – full time equivalent, NHS Digital)



American firms scooping up mental health contracts

KATE MISHKIN | Gazette-Mail

May 2019: in Charleston U.S. Attorney Mike Stuart announces a $17 million settlement with Acadia Healthcare over Medicaid fraud

The British market for private mental health hospitals grew by 4.1 per cent to £1.8 billion in 2018, and could grow to £2.3 billion by 2023, according to the latest report on the sector from private sector analysts LaingBuisson: – but the main customer in the market is the NHS, accounting for 90 per cent of it.

Much of this money is flowing across the Atlantic, according the Financial Times, based on new research showing the shocking extent to which American-owned health companies have taken over the provision of key mental health services in England.

US companies now run about 13 per cent of inpatient mental health beds in England, according to according to research by Candesic, a healthcare consultancy.

Half private

But in some areas, the proportion of US-owned mental healthcare facilities is much higher, such as Manchester, where half of all mental health in-patients are admitted to a privately owned hospital and a "one in four chance of the bed being provided by an American-owned company".

The imbalance is even more dramatic in child and adolescent mental health: recent reports reveal that no less than 44% of the £355m NHS spending on CAMHS care goes to private providers, and figures given in parliament last November again show how the private sector spend has grown by 27% over 5 years from £122m to £156m. .

The Candesic report estimates that in Bristol, North Somerset and Gloucestershire, 95 per cent of all mental healthcare beds are owned by private providers, two thirds of these owned by US companies.

Locked in profits

The private sector domination is most complete in the provision of "locked ward rehabilitation", in which in 2015 a massive 97% of a £304m market was held by private companies, the largest two of which are now US-owned, while 53% of all beds (locked and unlocked) for mental health rehabilitation are privately provided.

The Candesic report cited by the FT estimates that while about a quarter of NHS mental healthcare beds in England are provided by the private sector, a staggering 98% of these private facilities' earnings come from the NHS.

The big companies include the Nasdaq-listed Acadia Healthcare, which owns the Priory chain of hospitals, and Cygnet Health Care, owned by the NYSE-listed Universal Health Services, which has services worldwide including acute hospitals in Puerto Rico and the US.

Cygnet in 2017 reported operating 2,400 beds across 100 sites, with over 6,000 staff.

In the summer of 2018 it also took over the Danshell Group, operating 25 units with 288 beds for adults with learning difficulties. While Cygnet Health Care recorded a loss of £9.4m on turnover of £121m in 2017, the Group as a whole reported a very healthy profit of £40m on turnover of £334m.

The Care Quality Commission has just rated the Priory's Ellingham Hospital, in Attleborough, Norfolk, "inadequate" after it found that conditions, which included wards for children and adolescents, were "unacceptable".

Inadequate

Another two of the 53 facilities owned by the Priory in England are rated inadequate and a further six require improvement, according to the CQC, though the Priory said it frequently "takes on the most difficult cases which other hospitals aren't able or willing to treat".

Cygnet, runs 140 services across the UK: it closed a psychiatric unit in Durham earlier this year, after the BBC's Panorama filmed staff abusing patients.

It has since closed another hospital while a further five require improvement and three are rated inadequate by the CQC.

One mental health manager at the South London and Maudsley Foundation Trust told the FT the trust tries to avoid using private sector suppliers because they "inevitably keep the patients for too long as they have no incentive to encourage them to return to the community".

In Bristol, North Somerset and Gloucester-shire, 95 per cent of all mental healthcare beds are owned by private providers, two thirds of them owned by US companies.

Broken promises

In July 2017 Theresa May's new government promised 21,000 new posts for the mental health workforce to treat an extra million patients a year. Jeremy Hunt promised an additional 4,600 specially trained nurses working in crisis centres.

But the latest figures supplied by NHS Digital to NHS Support Federation confirm that there are 6,400 fewer mental health nurses and health visitors now than there were in 2010.

While there has been an increase of 2,108 community mental health nurses, the category of "other" mental health nursing – mainly hospital staff – has been cut by 26% – and fallen continuously since David Cameron first took office.

The number of nurses per patient has also dropped. In 2013 there was 1 mental health nurse for every 29 patients accessing services, by 2018 that had fallen to 1 for every 39 patients. 10% of specialist mental health posts are unfilled.

Just 4 in 10 people who need it receive mental health support.

But there's no relief in sight: the NHS Long Term Plan aims to be reaching just 35% of young people who need care … in ten years time.

Royal College maps a way towards less overcrowded wards

Despite warm words about 'parity of esteem' for mental and physical health since 2011, mental health services are the poor relation of the NHS, comprising 23% of NHS activity, but receiving just 11% of its budget.

A new report commissioned by the Royal College of Psychiatrists, Exploring Mental Health Inpatient Capacity, attempts to work forward from the current serious shortages of beds and unacceptable numbers of patients dispatched often long distances for "out of area treatment" (OATs).

The starting point for this study is the disparity in resources and treatment for mental health patients, for whom inpatient beds for those who need them have been cut by 73% since 1987 (from around 67,100 to 18,400) while numbers of "general and acute" beds have fallen by 44%.

While average length of stay in acute hospitals has fallen rapidly, the average length of stay for mental health remains largely unchanged over 30 years, at 7 weeks.

Raised threshhold, reduced admissions

The reduction in number of beds available in mental health services has been managed "largely through a reduction in the number of people admitted to hospital, and in some regions by the use of out of area placements.

"The thresholds for admission to a mental health bed have increased; the level of mental ill health of people admitted to hospital in 2018 was higher on average than individuals admitted in 2013.

"Furthermore, patients discharged in 2018, although deemed clinically fit for discharge, were on average less well than patients leaving hospital in 2013."

The RCP explains their approach:

"We commissioned this analysis to support our ambition that a psychiatric bed is readily and locally available for anyone who is acutely ill and in need of inpatient care.

"It is unacceptable for anyone under these circumstances to experience a lengthy stay in the emergency department, to be sent away from their local area to receive the care they need, or to be admitted to a general and acute bed where there is a relative lack of dedicated mental health nursing and psychiatric expertise.

"It is also a matter of equality. It would never be deemed acceptable for someone requiring acute coronary care to be admitted to a psychiatric ward."

Extra 1,060 beds

The report calls overall for an increase of 1,060 acute mental health beds, but notes that the problems of capacity are not evenly distributed and there are more severe problems in a few areas with the highest level of inappropriate out of area placement over the past two years:

● **Bristol, North Somerset and South Gloucestershire;** ● **Devon;** ● **Hampshire and the Isle of Wight;** ● **Lancashire and South Cumbria;** ● **Lincolnshire;** ● **Norfolk and Waveney and** ● **Nottinghamshire.**

However the College also argued that those areas with persistent 95 per cent plus bed occupancy should also consider investing in additional local psychiatric beds, notably: ● **Birmingham and Solihull;** ●**Cornwall;** ● **Mid and South Essex;** ● **North Central London;** ● **South East London and** ● **Sussex and East Surrey.**

"It would never be deemed acceptable for someone requiring acute coronary care to be admitted to a psychiatric ward"

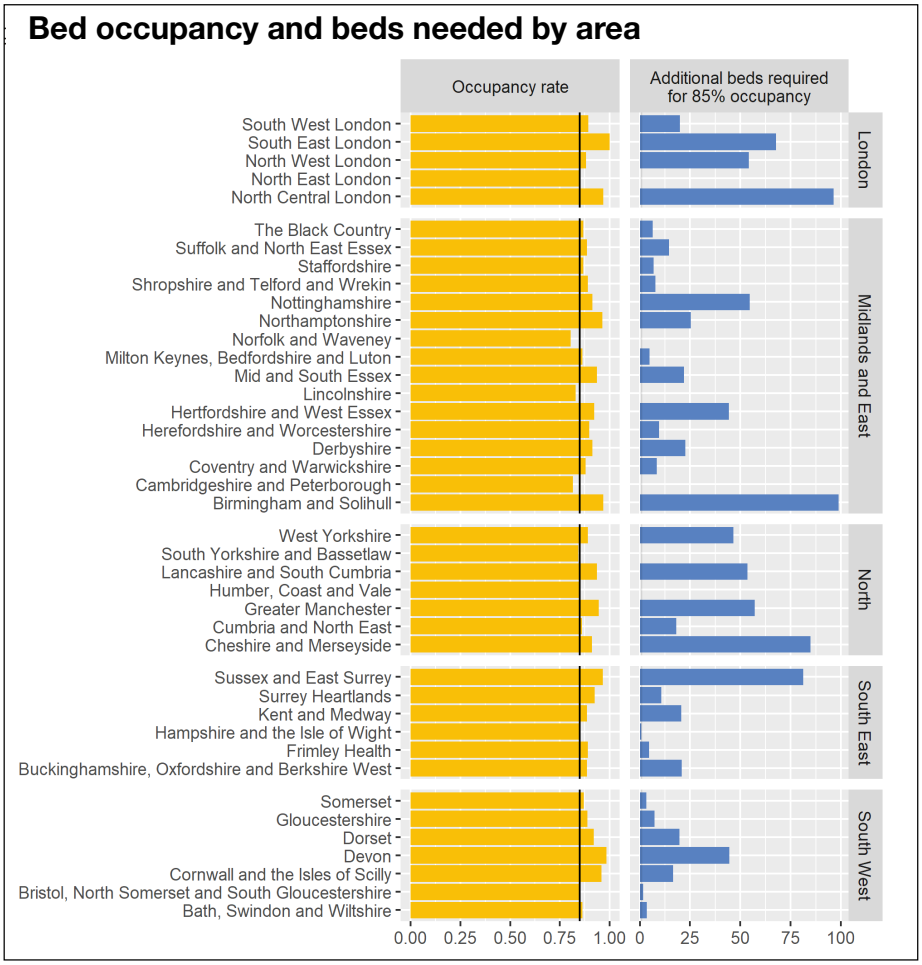
Review

In addition the College is pressing for a wide-ranging review of the mix of services provided and their effectiveness, to "maximise the therapeutic value of inpatient stays and undertake a local service capacity assessment", and urging commissioners to invest in high quality community mental health services.

But the bold call to reverse the continuing decline in bed numbers, with colourful graphics to highlight the numbers of additional beds requires to bring occupancy down to 85% and eliminate OATs will grab most attention.

While recent government announcements have reinforced feelings that mental health is treated as a poor relation of acute hospital care, this argues a strong case for more funding – explaining just where it needs to be spent.

Bed occupancy and beds needed by area



Charges and the 'Hostile Environment' in the NHS

Over the last two years, the once secret scandal of NHS charges for anyone unable to prove their entitlement to free care has provoked a storm of opposition from health workers unwilling to police the 'hostile environment'.

Keep Our NHS Public groups are working alongside campaigners from "Docs Not Cops", "Patients Not Passports", Medact, and Maternity Action.

The charges, broadly aimed at migrants but also affecting the Windrush generation, damage individual and public health. As the thin end of the wedge, they threaten wider charges for NHS treatment. They undermine the principle of universal health care, and contradict the NHS Constitution, medical and nursing ethics, and the responsibilities of all NHS staff to protect confidential information.

Instructing clinical and admin staff to act as border guards, places them in impossible contradictions and makes healthworkers unintentionally complicit with a policy that many feel is racist, and which may widen with Brexit.

GREG DROPKIN gives an extended overview of the problem and the campaigning around the issue.

Save Lewisham Hospital campaigners questioned Lewisham and Greenwich Trust over a *Guardian* report on the use of bailiffs to chase NHS patient debt. The Director of Midwifery and a consultant midwife expressed support, and were already auditing maternity outcomes.

The Deputy Finance Director mentioned MESH, the Message Exchange for Social Care and Health.

Campaigners were shocked to learn that the details of suspected "overseas visitors" are passed to the Home Office through MESH, even in batches of 5000 booked for outpatient clinics. The Home Office also contacts the Trust, telling them to charge people they suspect may have had care there.

The Trust claimed to avoid racial profiling via "objective" methods

Maternity

Last year, Maternity Action published "What Price Safe Motherhood?" based on anonymous interviews by Rayah Feldman with undocumented migrant women, about their experiences with maternity care. Many were victims of abusive relationships with men, compounded by the hostile environment.

"Natasha" overstayed her student visa and was deserted by her partner when she became pregnant. After her miscarriage, Natasha received an invoice for £4,900, a letter requesting payment within 7 days, and a letter from a Debt Collection Agency.

As a result, she was afraid to go back for a check-up or to find out what had caused this miscarriage or a previous one.

"My baby was buried and I couldn't even go. I was just so scared they were going to come and detain me. I went to see my GP, I was still bleeding then. They had to take me to the theatre to do a D&C. I haven't had any examination to see if it is all OK.

"At times my period is so painful, I feel cramps when I sit down, when I get up I can hardly walk sometimes. A lot of clots... I am scared to go to the hospital because I don't know how I will be able to pay. Even just to hear what caused the death of my baby. I am just thinking 'was I stressed?', 'was I not eating well?', 'was it a time I slipped on the stairs?' Or was it a medical problem? I don't know."

Vigil outside Lewisham Hospital

Duty of care

A new Maternity Action report "Duty of Care" highlights the contradictions facing staff.

The Nursing & Midwifery Council Code requires all nurses and midwives to "respect and uphold people's human rights" and "act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care."

One specialist midwife told of a refused asylum seeker with HIV who declined to continue antenatal care after receiving a large bill. She was considering delivering the baby at home without professional help.

Although HIV treatment is exempt from charging, maternity care is not. But without proper treatment, a woman may risk transmitting HIV to her baby during labour or afterwards. Further, HIV-positive women will be charged a higher price for their maternity care by virtue of their HIV diagnosis.

Her specialist midwife said "It's horrific, she doesn't trust anyone any more. She's very negative regarding her pregnancy.

She felt that the midwife in the booking was quite judgemental. Unfortunately it's left a feeling that people along the way are quite judgemental in considering why she's not married."

The midwife managed to access additional funding to continue the woman's antenatal care at home.

developed by personal credit checking company Experian, who share data with Trusts who then focus on those without credit history.

As the Health Service Journal reported, NHS Improvement, which oversees all NHS Trusts, began a pilot to extend the scheme without checking its legality, let alone morality.

NHSI emailed 51 Trusts explaining the aim to "refine a system that can conduct bulk residency checks on all admissions and referrals in secondary care", and to establish whether "this is an economically viable solution for use in all Trusts".

NHSI did not assess the impact on data protection:

"NHS Improvement has not reviewed Experian's processes and data sharing agreements for compliance either with GDPR or Caldicott principles." It advised Trusts to take their own legal advice.

Experian developed this system in partnership with Lewisham by 2015. The Trust now plans an independent inquiry. The campaign may propose Terms of Reference.

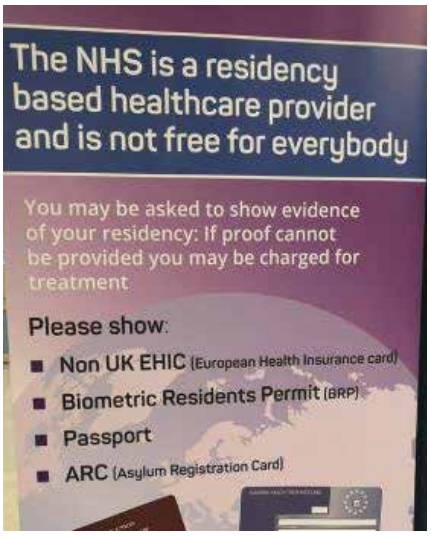
Many Trusts use the NHS England Pre-Attendance Form template. Patients sign their agreement to a Declaration which begins:

"This hospital may need to ask the Home Office to confirm your immigration status to help us decide if you are eligible for free NHS hospital treatment. In this case, your personal, non-clinical information will be sent to the Home Office.

"The information provided may be used and retained by the Home Office for its functions, which include enforcing immigration controls overseas, at the ports of entry and within the UK.

"The Home Office may also share this information with other law enforcement and authorised debt recovery agencies for purposes including national security, investigation and prosecution of crime, and collection of fines and civil penalties.

"If you are chargeable but fail to pay for NHS treatment for which you have been billed, it may result in a future immigration application to enter or remain in the UK being denied. Necessary (non-clinical) personal information may be passed via the Department of Health to the Home Office for this purpose."



NHS Improvement, which oversees all NHS Trusts, began a pilot to extend the scheme without checking its legality, let alone morality.

In law, NHS Trusts must determine if a patient is chargeable, but need not pursue national security, crime, fines or civil penalties.

The Pre-Attendance Form is a generalized fishing expedition which directly contradicts Caldicott Principles of information governance which apply to all NHS staff. For example:

"Principle 2 - Don't use personal confidential data unless it is absolutely necessary

"Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s)."

In March 2017, Public Health England wrote to the Health Select Committee (see pp 18-26) with evidence that sharing data externally acts as a deterrent to patients seeking healthcare:

Charging regime

Patients are checked for their entitlement to free NHS care, and this can be investigated by "Overseas Visitor Managers" in NHS hospitals. A&E and primary care are not currently charged.

There are exemptions for treating certain conditions (e.g. HIV, TB, trauma caused by torture) and for certain persons (e.g. refugees, asylum seekers).

People do not pay if they are "ordinarily resident" in the UK, but this term is undefined and is based on case law. A person's immigration status is fluid and NHS charges may apply during a possibly lengthy appeal process.

People from outside the European Economic Area / Switzerland are only deemed "ordinarily resident" if they have "indefinite leave to remain" in the UK.

Visitors with a visa over 6 months can pay the Immigration Health Surcharge, currently £400 / year per person to gain access to free NHS care. Care which is "immediately necessary" or "urgent" cannot be delayed and may still be charged, but otherwise the patient must pay upfront before treatment begins.

Charges are set at 150% of the normal tariff for people from outside the EEA / Switzerland. The Home Office can be told of unpaid debt, which may jeopardise immigration status.

For a full explanation and history, see Patients Not Passports

"Effective communicable disease control requires easy and early access to clinical investigations, screening, diagnostic testing, treatment and preventative measures.

"Patients provide information to healthcare providers with explicit assurances about confidentiality and this is the basis for unfettered sharing of demographic and personal health data by patients with health systems.

"If patients have concerns that their personal information, even simple identifiers, could be shared with law enforcement or immigration enforcement agencies for the purposes of pursuing them for actual or alleged breaches of law or immigration rules, then this risks creating a real barrier to their engagement..."

Reporting Debt in a City of Sanctuary

In July, the *Yorkshire Evening Post* published a letter from KONP Co-chair and retired Consultant Dr John Puntis, noting the ironic contrast of "Leeds as a city of sanctuary and its great tradition of welcoming immigrants" with

"the 'hostile environment' which now requires Leeds Teaching Hospitals NHS Trust (LTHT) to charge vulnerable and impoverished migrants for healthcare".

Dr Puntis also asked the Trust "Why does LTHT report patients with debts over £500 to the Home Office when such reporting is not mandatory?"

The Trust replied: "Although not a mandatory requirement, compliance is expected by NHS Improvement. The Trust has an obligation to take all steps available to recover the cost of providing care to those not eligible for NHS treatment and prevent the loss of public funds."

The issues are being raised within Unite, whose branch chair also chairs the Trust staff-side committee.

Royal Liverpool Hospital

In November 2018 KONP Merseyside and the Save Liverpool Women's Hospital campaign organised a Patients Not Passports conference, supported by Unite North West, Liverpool TUC, Unite branches and Garston & Halewood CLP. Speakers included Maternity Action, Docs Not Cops, Medact, South Yorkshire Migration and Asylum Action Group, Greater Manchester Law Centre, and These Walls Must Fall, with support from Refugee Women Connect and Asylum Link Merseyside.

Consultant Microbiologist Dr Jonathan Folb from the Royal Liverpool hospital attended and began raising the issue with Junior Doctors and other Consultants.

In January, 60 medics and public health academics met at the Medical School, with input from Docs Not Cops and KONP. Medics expressed outrage at the charges and their implementation in the hospital. KONP later learned that the charges to "overseas visitors" in 2018-19 amounted to 0.12% of total patient care income, and only 0.04% was actually paid, negating any economic argument for the regime.

In a survey of Junior Doctors and Consultants, over 100 of each group responded, and over 90% of each stated opposition to the charges. The Joint staff-side, with unions representing all other NHS staff in the hospital, is also supportive.

A campaign statement inviting signatures was placed on the Medact website.

The local GP surgery dealing with asylum seekers and refugees wrote to the campaign, ccing the Trust Interim CEO and Chair, "[To] restrict access to necessary healthcare is, in the opinion of the Board of PC24, neither in the spirit of the NHS nor the ethos of Liverpool as an asylum city. As an organisation, Primary Care 24 fully supports your campaign and will help in any way we can to bring this practice to an end."

In July, medics convened a Grand Round (to discuss issues and individual cases), with participation from the GP surgery and migrant support group "Refugee Women Connect".

The Acting Medical Director invited Consultants to redraft the Trust policy. It turned out there is currently no agreed policy, only a draft, but the charging regime is operating.

This offer posed a difficult question. Medics had to decide whether accepting it would make them complicit in a regime they completely oppose.

On the other hand, patients are being charged, posters are up and women wearing a headscarf have been asked for their passport at A&E.

The Overseas Visitor Team become involved before clinical teams have had time to properly assess urgency or clinical exemptions. The OVT read and append the clinical notes, and interview relatives while patients are undergoing treatment, pulling in staff to interpret.

Over the summer, medics decided to redraft the policy. On 23 Oct, the second anniversary of the introduction of upfront charges, a campaign meeting attended by Consultants, senior staff, Junior Doctors from the Royal, Aintree and Warrington hospitals, the Walton Centre, medical students and a former interpreter endorsed this approach and agreed to submit an updated version for negotiation with Liverpool University Hospitals NHS Foundation Trust (merger of Royal and Aintree).

The draft policy is introduced as an interim measure to mitigate harm as far as possible while remaining within the 2015 and 2017 Regulations.

The draft opens by referring to "First Do No Harm", the GMC Duties of a Doctor, the Duty of Care covering all staff and the Trust itself, and the Caldicott Principles.

It acknowledges the concerns expressed by staff and endorses calls from the British Medical Association, Academy of Medical Royal Colleges, and the Royal College of Midwives, for the regulations to be repealed or suspended pending a full and independent review into the impact of charging on individual and public health.

The draft policy is introduced as an interim measure to mitigate harm as far as possible while remaining within the 2015 and 2017 Regulations. It sets out procedures to identify exemptions, with charges as the last resort and without a target in the Business Plan.

No charges, publicity or inquiries will occur in the Emergency Department or Sexual Health (GUM). Only clinicians will access clinical data. Limited non-clinical data will only be shared with the Home Office on an individual basis with patient consent, in line

with Caldicott, after other attempts to find exemptions have failed.

Patients will have access to advocates and interpreters on request, and appeal rights. The Trust will not use external debt recovery agencies and will not report debt to the Home Office. The draft sets out roles and responsibilities for each staff group including the Overseas Visitor Team. It requires the Trust Board to monitor the policy's full impact on Patient Safety, Equality and Diversity and on the health of patients who present, or could otherwise be expected to present, to the Trust.

Major problems will remain until the law is repealed. But campaigners and hospital staff hope that Liverpool University Hospitals will choose to stand alongside the BMA and others in calling for a change in the law, while protecting patients and staff in the interim.

The BMA Mersey Junior Doctors Committee wrote to the campaign in July, expressing support in line with BMA policy (below), and concluding:

We also as a local committee support your call to Royal Liverpool University Hospital to make a public statement acknowledging the concerns of its staff, and encourage them to support the calls from BMA and other key stakeholders to abandon charging, and to take immediate interim measures to reduce harm to vulnerable individuals, ensuring the NHS is free for all at the point of delivery.

BMA and Royal Colleges

The **BMA Annual Representative Meeting (ARM)** in June overwhelmingly adopted Motion 42 from Tower Hamlets Division:

That this meeting notes that in a pilot to check eligibility for free NHS Care only 1/180 people were deemed ineligible and:-

i) this meeting believes that it is not cost effective to monitor eligibility for NHS Care;

ii) this meeting calls for the policy of charging migrants for NHS care to be abandoned and for the NHS to be free for all at the point of delivery;

iii) that this meeting believes that the overseas visitors charging regulations of 2011 threaten the founding principles of the NHS and that the regulations should be scrapped.

The **Academy of Medical Royal Colleges** called for "the suspension of the NHS charging regulations pending a full and independent review of the impact on both individual and public health" and "a clear separation of roles between immigration enforcement activities and the provision of healthcare".

Campaigners and hospital staff hope that Liverpool University Hospitals will choose to stand alongside the BMA and others in calling for a change in the law, while protecting patients and staff in the interim.

The **Royal College of Midwives** Chief Executive Gill Walton, introducing the Maternity Action "Duty of Care" report, stated:

"We believe that maternity care should be exempt from NHS charging altogether to protect and promote maternal and newborn health. The current charging regime needs to be suspended until the government can prove this policy is not doing any harm and jeopardising our shared ambition to make England the safest place in the world to have a baby."

Labour

Labour Party Conference agreed NHS Composite 2 which includes:

"Conference supports health workers' duty of care to migrants and opposes migrant charges. Labour will repeal Sections 38 and 39 of the Immigration Act 2014 and subsequent regulations which implement migrant charges."

A motion from **Labour Women's Conference** was adopted overwhelmingly.

"Annual Women's Conference deplores the 2017 introduction of NHS charging regulations requiring undocumented and destitute migrant and refugee women to pay 'up front' charges for ante-natal and maternity care.

…

"We resolve to:

"call on the Secretary of State for Health and Social Care and the Government to rescind the Regulations – and meanwhile suspend them pending research on their impact

"call on the Shadow Secretary of State for Health and Social Care to express Labour's opposition to charging and agree to rescind the policy under a Labour government".

FURTHER INFORMATION:

ARTICLES AND BRIEFINGS

- Another key Johnson claim on the NHS demolished
- Healthcare workers blockade NHS England and hold vigils at six Hospitals to protest charging for migrants in the NHS
- British politicians' NHS hypocrisy laid bare today on the global stage
- How NHS staff are fighting back against the 'hostile environment'
- Patients Not Passports Briefing:
- Patients Not Passports toolkit:
- Patients Not Passports Letter to Health Secretary:
- KONP leaflet:
- KONP:
- Speech by Cathy Augustine:
- Speech by Sonia Adesara: (section begins 8:05)
- Maternity Action legal challenge:
- Speech by Sarah Davies:

Contacts

If you are a member of a trade union which organises within the NHS, please seek their support in defending universal healthcare. Active campaigns include East London (Newham, Waltham Forest, Hackney, Tower Hamlets, Barts Hospital), Lewisham, Southwark, Brighton, Bristol, Oxford, Cambridge, Nottingham, Leeds, Manchester, Liverpool, and many other individuals.

Medact: Docs Not Cops: Patients Not Passports: Doctors of the World: Maternity Action: Keep Our NHS Public:

THE lowdown

In our first year we pledged to:

- establish a regular one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally.

To go into a second year we need **YOUR HELP**

The Lowdown launched in February 2019 with our first pilot issue and a searchable website. Our initial funding came from substantial donations from trade unions and a generous individual.

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – **something that was not previously available to NHS supporters.**

Our mission is to inform, explain, analyse and investigate issues and ensure that the founding principles of the NHS are upheld, in policy and practice.

Our editors and main contributors are **Paul Evans** of the NHS Support Federation and **Dr John Lister** (London Health Emergency, Keep Our NHS Public and Health Campaigns Together) who have almost 60 years combined experience between them as researchers and campaigners.

The aim of the project has been to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

To get it under way, we have worked hard to get the name established, build a core readership, and raise money where we can.

We need to make the project self-sustaining, so we can pay new journalists to specialise, and undertake investigations and research that other organisations aren't able to take on.


THE lowdown

Health news, analysis and campaigns. NUMBER 11, October 12 2019

Informing, alerting and empowering NHS staff and campaigners

RCP warns of vacancies

Private GP service sets sights on further NHS expansion

Paul Evans

Babylon health plans to expand its virtual GP service to Manchester after its reported success in attracting NHS patients to use its GP at Hand business.

The private company, which offers fast GP appointments by video has attracted over 60,000 NHS patients in Birmingham and London and if its plan is accepted will be up and running in Manchester by early 2020.

The CCG backed the expansion to three major cities, under current regulations patients who sign-up for GP at Hand are all registered with Babylon Health's GP practice in Hammersmith & Fulham in West London; so it's this CCG that will be required to give approval for the expansion to Manchester.

Problems for CCG

Babylon's expansion in this way has led to major financial problems for Hammersmith and Fulham CCG as it is responsible for thousands of new patients registered on GP at Hand whether they live in their area or not.

The CCG eventually gave approval for the expansion to Birmingham, with the proviso that no more than 2,600 patients be registered in the area in the first three months.

However, changes announced in late September by NHS England and NHS

The app will see you now ...

New contracts for 'digital-first' GP providers will probably require them to set up a physical clinic in the area

Improvement will change this and have a significant effect on the way Babylon Health operates from June 2020 onwards when they come into force.

The new contracts will remove patient registration and mean that once 1,000 patients are registered in a CCG area by a provider outside this area, then the provider will be issued with a new APMS contract covering that area.

Financial burden

This means the patient list is divided up and no single CCG bears the financial burden of thousands of extra patients registering.

GP at Hand has approximately 60,000 patients living outside Hammersmith and Fulham, and these patients will now have to be divided into 17 different lists in areas where GP at Hand has more than 1,000 patients.

Other changes mean that in the areas where the new contracts are issued to the digital-first GP providers they will probably be required to set up a physical clinic in the area.

There is also a proposal that new digital primary care providers should be required to set up in areas lacking doctors and primary care access is poor.

Figures obtained by GPonline suggest that more than one in four NHS patients who registered with Babylon GP at Hand quit the video consultation service within just over a year.

A successful Mental Health Summit on September 28 organised by campaigners including Keep Our NHS Public and Health Campaigns Together has now published video and reports as part of a drive for more concerted campaigning.

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https://lowdownnhs.info/ contactus@lowdownnhs.info

We have had some success, and thank those individuals and organisations who have donated.

But seven months on, we need to step up our efforts to raise enough money to take us unto and through a second year, enough for us to be able to reach out and offer work to freelance journalists and, designers.

This autumn we will be making a fresh appeal to trade union branches, regions and national bodies – but also to individual readers.

We are providing this information free to all -- but it is far from free to produce.

If you want up to date information, backed up by hard evidence, that helps campaign in defence of the NHS and strengthens the hand of union negotiators, please help us fund it.

We urge those who can do to send us a one-off donation or take out a standing order.

More details of this and suggested contributions are in the box below.

Our commitment is to do all we can to ensure this new resource remains freely available to campaigners and activists.

Without your support this will not be possible.

Help us keep The Lowdown running in 2020

We really want to run this publication without clumsy paywalls that would exclude many activists – but if we are to develop new expertise we do need to recruit staff, and so we need the resources to pay them.

We have therefore always planned to fund the publication through donations from supporting organisations and individuals.

We urge union branches to send us a donation … but also please propose to your regional and national committees that they invite one of our editors to speak about the project and appeal for wider support.

We know from our surveys that many readers are willing to make a contribution, but have not yet done so. We are now asking those who can to give as much as you can afford. We would suggest £5 per month/£50 per year for individuals, and at least £20 per month/£200 per year for organisations: if you can give us more, please do.

Supporters will be able to choose how, and how often to receive information, and are welcome to share it far and wide.

On the website we will gratefully acknowledge all of the founding donations that enable us to keep this project going into a second year.

- Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG
- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at *contactus@lowdownnhs.info*