The lowdown

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

To get the NHS out of this hole – stop digging

In the ten years from 2000 on, a decade of sustained investment by a New Labour government managed to repair much of the damage that had been done to the NHS by 21 years of under-funding. In 2010 David Cameron's government threw that into reverse with a new decade of austerity.

That's why the performance of England's NHS is now the worst-ever, with sky-high – and still rising – waiting lists, huge delays in emergency services and dwindling numbers of GPs struggling to deliver increased numbers of appointments.

Latest figures show that fewer than 100,000 acute beds are available, and also a record 96% bed occupancy.

It's this lack of capacity that is causing desperate delays. In November 37,837 patients waited more than 12 hours on

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trolleys in A&E, a 34-fold increase from 1,111 before the pandemic in November 2019 – despite numbers of emergency admissions almost 8% lower than 2019.

In England there were more 12-hour trolley waits in January-November 2022 (293,275) than in the previous 10 years combined: recent trolley waits have been as long as 99 hours. It was not strike action or Covid that almost doubled England's waiting list from 2.5m in 2010 to 4.6m at the end of 2019; nor have strikes been the cause of the subsequent rise to 7.2 million.

It was not industrial action, but systematic government under-funding and lack of NHS capacity that meant 2.91 million patients had been waiting over 18 weeks for treatment in October 2022, 410,983 of them waiting over a year.

Shortages of staff, beds and cash have meant key cancer performance targets have not been met since 2014: and when Boris Johnson called the general election in December 2019 more than one in five cancer patients was already waiting more than two months to start treatment.

There are also grim delays in accessing mental health care for adults and for children – with increasing use of long-distance referrals to private beds for lack of NHS capacity.

The other side of capacity is staffing: a widening gulf of unfilled vacancies, up 29% in a year to 133,000 including one in eight nurses, as exhausted and frustrated staff leave, some for better paid jobs, others to escape the stress and trauma of trying to keep services going and patients safe.

A political choice

The Royal College of Emergency Medicine warns the emergency delays could be costing between 300 and 500 people their lives per week; ambulance chiefs have warned 160,000 patients a year are being harmed; the Society for Acute Medicine warns the situation in A&E is "unbearable," the NHS Confederation is now arguing the lack of capacity flows from 12 years of austerity, and the BMA chair Prof Phil Banfield has insisted that the under-funding has been caused by a "political choice" made by this and previous governments since 2010.

Even the Tory loyalist Daily Telegraph has admitted that there was no crisis and that performance was strong on waiting times and emergency care when David Cameron's government in 2010 took control and slammed the brakes on NHS funding.

Telegraph and other right-wing pundits predictably blame NHS management, claiming the NHS has been showered with money. Some (including Labour's shadow health sec-

retary Wes Streeting) demand more use of private hospitals – despite the evidence that billions have been wasted on such schemes, especially during and since the pandemic, and the harsh fact that private hospitals are no use at all for emergency care, and can only gear up to treat more NHS patients by poaching more staff from NHS hospitals.

Other right wingers and think tanks go further, to argue that the NHS model itself should be discarded in favour of (more expensive) European-style systems, of which they know little and understand less, other than that their beloved private sector plays a more central role.

Yet despite all these red herrings a poll has found that almost three in every four (73%) of Conservative voters think their government is responsible for the mounting crisis in the NHS: only 16% think they are running it well.

They have not been fooled by ministers mouthing empty phrases like "record funding," which relates only to the nominal cash increase almost every year since the NHS was formed: it the real terms value, and the increases needed each year to cope with rising population and health needs.

NHS England admitted in October it has to deliver annualised savings of £12 billion by 2024/25: these cutbacks have yet to take effect. But Chancellor Jeremy Hunt's autumn statement covered just half the projected additional £6-£7bn inflation costs with "extra" funding.

So – irrespective of any additional pay settlement – the financial situation of the NHS will only get worse right up to and after the next election, since sadly the Labour Party that is ahead in the polls is currently refusing to promise any additional funding for the NHS.

John Lister

This article was also published in Tribune magazine.

Bypassing your GP – self-referral, a good idea?

The Labour leader, Kier Starmer, in a piece published by the Telegraph and on the BBC last weekend said his party was going to tackle "bureaucratic nonsense" in the NHS and argued that people should be able to self-refer to a physiotherapist for back pain or to order a test for "internal bleeding" rather than having to see a GP.

The reaction on social media and in subsequent media articles was swift, with many medics appalled at the idea wondering if Starmer had actually spoken to any doctors. However, this opinion was by no means universal.

Dr Martin Brunet, a GP and medical educator from Guildford, said on Twitter: 'Self-referral to specialists is a terrible idea. This is because primary care and secondary have a totally different approach since we see a different cohort of patients."

In contrast Ed Turnham, a GP partner based in Norfolk, wrote a thread on Twitter on why self-referral is possible in certain situations and if the right technology is used.

Although the NHS has developed over the years with the GP gatekeeping system in place and referrals from GPs being the only way to access a specialist, there are some notable exceptions, we self-refer for hearing tests and eyesight tests.

More recently, in many areas it has become possible to self-refer to a physiotherapist, for alcohol and drug treatment, stop smoking services and across England it is possible to self-refer for mental health treatment involving talking therapies. People can also go directly to clinics that deal with sexual health services and you can register for ante-natal care all without troubling a GP.

There is already a push from NHS England for more self-referral. In its planning guidance in December 2022, it states that systems should aim to:

"Expand direct access and self-referral where GP involvement is not clinically necessary."

By September, systems should be in place for the following:

– direct referral pathways from community optometrists to ophthalmology services for all urgent and elective eye consultations
– self-referral routes to falls response services
– musculo-skeletal physiotherapy services
– audiology, including hearing-aid provision
– weight-management services
– community podiatry
– wheelchair and community equipment services

A quick look at these areas and it is clear that GP involvement is not necessary. Why would a GP referral be needed for a wheelchair or podiatry?

The complexities begin when self-referral to hospital-based consultants is considered. It is the possibility that this could happen that has caused the biggest outcry.The example of "internal bleeding" used by Starmer, was perhaps not the best one to use, because it can be a symptom of many conditions.

However, there are other conditions, where the symptoms are not as general. Dr Ed Turnham, a GP and clinical advisor on digital strategy in Norfolk ICB, noted on Twitter "why not allow direct access for conditions such as breast lumps, where certain criteria are met?" and added "a GP appointment *might* save a referral to the breast clinic, but every time it doesn't means 2 appointments where there could have been one."

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In the arguments on self-referral other country's healthcare systems are often cited as examples where self-referral is possible. The most common example is France, however France has moved away in recent years from self-referral being the norm, to a system of GPs acting as gatekeepers. Now, although it is still possible to self-refer to specialists, there are financial incentives offered to those who opt to register with a GP or with a particular specialist, who can also act as a gatekeeper. About 95% of the population have chosen a GP as their gatekeeper.

Seeing a specialist without a referral from a gatekeeping doctor will cost the patient as there will be reduced Social Health Insurance coverage (there are exceptions).

Germany, another country often brought into the discussion, does not have a tradition of GPs acting as gatekeepers to the health system. The system developed with individuals having free choice among GPs and specialists, and registration with a family doctor is not required. However, the country's sickness funds, which run the healthcare system, are required to offer members the option of enrolling in a family doctor (GP) care model, and they often provide incentives for complying with gatekeeping rules. Because of the way Germany's healthcare system has developed, there are many more specialists so self-referral does not result in a long-waiting time.as well, otherwise the waiting lists will only lengthen..

'Genuine' patients could lose out

In both France and Germany, although self-referral is no longer encouraged, the system has developed in a culture where it has always been possible. In the UK the population and specialists have always used a system of GP gatekeepers, and there are questions over how the population would react should more direct access be allowed and how specialists would cope with an influx of patients unfiltered by primary care.

There are concerns over people making unnecessary self-referrals that would mean restricting access for genuine patients, as Dr Martin Brunet noted on Twitter:

'Clogging up the secondary care system with unfiltered primary care patients will make it harder for genuine secondary care patients to get access, with delays to diagnosis and treatment a significant risk of patient harm.'

However, Dr Clare Gerada, President of the RCGP, has noted that there is an argument to be made for allowing some patients with long-term conditions, such as in rheumatology, serious mental health and some cancers, self-refer back to the team that treated them at the start.

There are many questions over self-referral: how would a patient know what tests to order or which specialist to choose? How do you prevent patients choosing the wrong pathway for themselves – the wrong tests, the wrong specialist, which could slow down their time to treatment? How do you cope with those people for whom "Dr Google" is their guide and won't listen to any other?

A major consideration will be cost. A systematic review published in the British Journal of General Practice in 2019 of 25 studies worldwide found that gatekeeping was associated with lower healthcare use and expenditure. The same review found it was associated with better quality of care, but with lower patient satisfaction.

Potential impact on costs

Without some form of gatekeeping, cost containment becomes harder. One of the reasons France and Germany's healthcare systems give incentives to register with a gatekeeping GP is that it is cheaper for the overall healthcare system. It is easier to contain costs if the number of patients who self-refer is kept low.

At the moment GP referrals are closely monitored as a way to control costs. Referrals are often turned down and sent back to the GP. For example in mental health, GPs have complained that the only way a referral will be accepted is if a patient has attempted suicide and often resort to recommending that a patient seeks private help as a referral will get rejected. How then will self-referral not lead to a massive escalation in cost for the NHS, as patients who could have been treated by the GP self-refer to specialists, bypassing all the checks and controls currently on GP referrals.

If specialists become inundated with patients self-referring, who they then have to assess for treatment, will add time and cost to the procedure.

As Dr Martin Brunet outlines on Twitter, specialists and GPs see different cohorts of patients. GPs see many where initial treatment could be by the GP or a wait and see approach be taken, whereas specialists see a cohort that are at a different stage. He notes: "Secondary care patients have already been screened as being more likely to have a serious problem and so it is right to consider all the possible causes, not just the probable ones and do the right tests to investigate them all…Self referral will lead to inefficiency, unnecessary tests (and associated patient harm) and huge costs."

One possibility, outlined by Dr Ed Turnham on Twitter, is the use of technology to triage patients as part of the process of self-referral. He notes that there "is a huge opportunity to use technology-assisted triage to help patients go straight to specialists. This will provide more timely care, preserve NHS resources, and relieve strain from GPs…Direct access to consultant-led services would be for patients who meet tightly-defined criteria." Such triaging would lead patients who do not fulfill the criteria back to their GP.

However, as Turnham points out such triaging will need considerable investment in IT, not something politicians like spending money on. If self-referral is going to increase in any form, then considerable investment is going to be needed in the workforce as well, otherwise the waiting lists will only lengthen..

Urgent care provider in special measures

Four urgent care treatment centres run by Partnership of East London Co-operatives (PELC) Limited have been rated 'inadequate' by the Care Quality Commission (CQC) and put in special measures.

The centres, King George's Emergency Urgent Care Centre (EUCC) in Goodmayes, Queens Urgent Treatment Centre in Romford, Harold Wood Urgent Treatment Centre in Harold Wood, and Barking Urgent Treatment Centre in Barking, were inspected in October and November 2022, and inspectors found patients were "routinely waiting more than two hours for a clinical assessment."

Two of the centres are attached to hospital emergency departments and treat the majority of patients that arrive with minor injuries and illnesses.

The CQC director for London, Jane Ray said that, "Although each service suffered from short staffing, which was a factor behind the long waits and an issue affecting the NHS more widely, PELC's leaders must prioritise meeting NHS England's standard of clinically assessing people within 15 minutes of arrival."

Ms Ray added: "Behind this [failure] was the failure of the service's leaders to effectively monitor issues the services faced, including waiting times, to inform their strategies to meet people's needs."

The CQC noted that PELC had last conducted a comprehensive workforce planning exercise five years ago and now rota gaps constituted at least 10% for doctors and at least 20% for nurses.

However, the CQC rated the services good for being caring, as "despite the pressure they were under, staff in each service treated people with kindness, respect and compassion."

The special measures rating means the CQC will closely monitor the services and they will be inspected again in the coming months to assess whether improvements have been made.

Following a system-wide CQC review of east London's urgent and emergency care in November 2021, King George's Emergency Urgent Care Centre was previously rated 'good' and the other services were rated 'requires improvement'.

PELC is a not-for-profit organisation formed in 2004 by local GPs, that delivers UTCs across east London and west Essex, under a contract with the North East London integrated care system (ICS)..

Mixed reception for hospital discharge scheme

The government announcement of an extra £200 million to move patients fit to discharge from NHS beds to care homes, and other settings, has received a mixed reception – NHS leaders say they need the money as soon as possible to begin freeing up beds and are concerned there will be delays, in contrast social care leaders warn that the pressure to discharge patients fast has already led to inappropriate placements and the scheme is just another "sticking plaster" that doesn't address the long-term problems.

There are an estimated 13,000 people in NHS hospitals that are fit to discharge and the scheme, announced by Health and Social Care secretary Steve Barclay, aims to free-up around 2,500 beds by funding "maximum stays of up to four weeks per patient" in care homes or other settings. The scheme runs for just three months to the end of March 2023.

The scheme is similar to the national discharge scheme begun in 2020 as the NHS needed beds for Covid patients, which led to thousands of patients moving out into care homes. Funding for this scheme ended in April 2022.

This £200m is in addition to the £500m adult social care discharge fund (ASCDF), announced in September 2022. However, Barclay claims that the extra £200m means the NHS will be able to "immediately buy up beds in the community."

NHS leaders fear, however, that the distribution of the money will be as slow as the £500m ASCDF.

It took many weeks to distribute the first £200m of the ASCDF,

and the final £300m is only now being distributed to organisations.

One national NHS leader told HSJ: "If this announcement is to be anything more than politically-driven theatre and have an impact before the start of spring, then the money needs to be in place in the next week to 10 days."

In contrast, The British Geriatrics Association (BGA), the Association of Directors of Adult Social Services (ADASS), the Local Government Alliance (LGA), and charities that work with the elderly, fear that the rapid discharge of people from hospital means they could end up in care homes or hotels which are totally unsuitable for their needs. The BGA noted:

"In order for this to have the intended impact, care homes must be able to provide the necessary rehabilitation to help older people recover. This requires expert input from nurses, therapists and medical staff. If this expertise is not in place to aid recovery, then older people's health will continue to decline and hospital readmission becomes more likely."

The ADASS is also concerned about the focus on care homes, when if the right care package is in place, home is the best place. Chief executive Sheila Norris noted:

"Use of the funding should be guided by the 'home first' principle, rather than the default being that people are discharged into care homes. Otherwise we run the risk of people being inappropriately placed and then remaining in residential provision indefinitely. Legally, and morally, it is right that they have a choice about where they live."

Hotels are no solution

Hospitals in Devon, Cornwall and Dorset are already discharging patients into hotels. With beds booked in hotels in Plymouth and Bournemouth for what are described as "medically fit guests" with social care needs.

Louise Jackson, health and care manager for Age UK, told the BBC that care hotels were "unlikely to be appropriate settings" and added that "this is another sticking plaster, whereas what we need is sustained core investment."

This constant reliance on short-term funding schemes, means that nothing has been done to tackle the root problems of why so many people are ending up in hospital. David Fothergill, chairman of the LGA community wellbeing board told Community-Care:

"A decade of consistent underfunding of social care and underinvestment in community health services has led us into this crisis and it will not be fixed through tacked-on funding that fails to address any of the root causes of this situation."

Fothergill added:

"Until the government presents social care as an essential service in its own right – valued equally highly as the NHS – we will continue to lurch from one sticking plaster to the next".

Jane Townson, Chief executive of the Homecare Association, the membership body for home care providers, highlighted that the 13,000 people waiting to be discharged from hospital was a small fraction of the approximately 500,000 awaiting a social care assessment or service, according to ADASS data.

"We need to fix the problem at both ends," she said, "buying up care home beds is a necessary sticking plaster for this winter but does not address underlying causes, so people will continue to be left waiting for care at home."

It is clear that these short-term funding schemes also do not address one of the major issues in social care, the workforce crisis.

Staff shortages impacting on capacity

Home care providers can not provide the capacity needed to meet demand, according to Townson, as they were unable to recruit and retain staff, with vacancy rates of 14.1% as of October 2022. Overall, there were 165,000 vacancies in social care, up 52% over the previous year. With the median hourly rate of a care worker listed as just £9.50 and with an HCA with two years experience getting only £11.30, it is clear that pay is an issue. Supermarkets and other retail outlets pay more.

Without a plan for long-term funding increases, however, neither homecare companies nor care homes can invest in new staff or increase pay rates. Martin Green of Care England, which represents the largest private care home providers, has said it wants the government to pay them £1,500 a week per person, citing the need to pay care workers more and hire rehabilitation specialists. The current rate of pay is described by Green as "inadequate".

More than anything, however, the industry would like a long-term plan, as the chief executive of the National Care Forum Vic Rayner told Community Care:

"There may not be enough money, but make a plan, provide some certainty to enable organisations to take on new staff, to invest in new facilities and to develop their in-house rehabilitative resources. Without this long term vision, all of this money will be swallowed into short term fixes such as over reliance on agency staff, or the prioritisation of hospital patients over those with urgent needs in the community."

And as the BGA notes what happens after the three months of funding ends, it will be the same problems just in a few weeks time:

"There is a risk that discharging older people to care homes will simply move the problem down the line and we will be in the same crisis situation in two to three weeks as older people come to the end of the funding period and have ongoing health and social care needs.".

NHS pre-Christmas edicts: grim reading for health chiefs

The list of impossible tasks... the customary pre-Christmas Eve letter to NHS bosses and leaders setting objectives for the next financial year was significantly shorter than usual in 2022, with the list of impossible things to do scaled back from 130 or so to 31 "national objectives": but even the reduced list will have made grim holiday reading and set up the NHS in many areas for fresh failures well before the new year even started.

The whole document and the list manage to avoid any mention or reference to the ongoing pay dispute, or the inflationary crisis which is the background to it, but which affects NHS trusts as well as the pay packets of staff who have had no real terms pay increase for well over a decade.

With their eyes and ears firmly blinkered and blocked to the real world, NHS England bosses manage to combine setting completely improbable targets with actual retreats. Eagle-eyed HSJ correspondents have identified a series of targets and ambitions that have been dropped altogether this year, including previous priorities on long covid and diversity and inclusion, commitment to support the health and wellbeing of staff, and continued funding of mental health hubs for staff.

From the very first line the one-page summary list of objectives (page 7) marks a retreat from previous stated targets, with a call somehow to reduce A&E waiting times "so that no less than 76% of patients are seen within 4 hours by March 2024" – effectively abandoning any hope of returning to the 95% target, which has not been achieved since 2015.

The most recent figures (December 2022) show an overall average of just 65% of A&E patients treated within 4 hours, but just 49.6% of the more serious Type 1 cases which are more likely to result in emergency admission. This is the worst performance on record.

SIXTEEN trusts fell below 40% of Type 1 cases treated within 4 hours in December. This is a big increase from six in November. (They were: Somerset; Royal Cornwall; Mid Cheshire; Manchester University; Hull; University Hospitals North Midlands; Derby & Burton; Shrewsbury & Telford; Hillingdon Hospital; Chesterfield; East and North Hertfordshire; West Hertfordshire; North West Anglia; Kings College, plus two trusts, Torbay and Devon (29.2%) and Barking Havering and Redbridge (28.6%) dipping below 30%.

54,532 emergency patients were delayed for 12-hours or more in A&E from decision to admit to admission, again the highest number of 12-hour waits on record, up 10,740 from the second highest figure on record, October 2022, and 2,223% higher than December 2019.

As we have pointed out before in The Lowdown, the markedly poorer emergency performance in 2022 comes despite an actual drop of almost 15% in the numbers of attendances in A&E, and a decrease in the proportion of the more serious Type 1 cases from 53% in December 2019 to 47% in 2022.During the whole of 2022 (January-December) the total number of patients attending A&E fell by 18% compared with 2019, while the numbers of Type 1 cases fell by almost 25%.

The problem, after 12 years of inadequate investment in buildings, beds and staff is clearly lack of capacity – in the hospitals themselves and in the social care and community health services that are supposed to be available to facilitate prompt discharge of patients who no longer need a front line acute bed.

So even achieving the new 76% target by March 2024 will be a stretch for most trusts, especially since NHS England makes clear there is no additional real terms funding for the next two years.

Yet somehow NHS England also expects trusts to reduce adult general and acute bed occupancy to 92% or below. This came as figures showed pressure on beds at its highest-ever, with weekly Covid admissions data showing more than 96% of 95,844 adult general and acute beds were occupied on January 4.

NHS England does not plan to reopen any additional beds, but calls on acute trusts, somehow, with no extra funds, to “permanently sustain the equivalent of the 7,000 beds of capacity that was funded through winter 2022/23”.

GP services

Community health services are expected somehow to “reduce unnecessary GP appointments,” while the declining number of GPs who have already been delivering a staggering record number of appointments (36 million in October – equivalent to more than half the UK population) are expected to deliver 50 million more appointments by the end of March 2024.

For once NHS England observes a welcome silence on the proportion of GP appointments that should be face to face – an issue right wing politicians and the right wing news media have obsessed about. After even the pro-NHS Daily Mirror managed to invert the figures by claiming “just 73.4% of GP appointments took place face-to-face in October” Pulse editor Jaimie Kaffash has published new research aimed at establishing the facts.

It has revealed the inevitable trade-off between prompt access to an appointment and the proportion of face to face appointments:

“Our investigation showed what many GPs will already know: that to offer face-to-face consultations, practices generally can only provide lengthier waiting times and fewer appointments conducted by GPs. The table below show that those in the bottom decile for face-to-face appointments have the shortest waiting times at just under five days, while those that offer the highest percentage of appointments that are face to face have an average waiting time of just under eight days.

Pulse analysis of NHS Digital data reveals that: “almost half of all appointments – 46% – are taking place within a day of the booking. Meanwhile, 69% were seen within a week. Pulse analysis showed that the average wait is a week exactly.

“Nonetheless NHS England is now insisting, again with no additional resources on offer, and even as demoralised GPs leave in disgust: “everyone who needs an appointment with their GP practice gets one within two weeks.”

GPs are also lumbered with the heavy lifting to deliver two of the three tasks for prevention: increasing the proportion of patients with hypertension receiving treatment and implementing new NICE guidance to ensure up to 15 million more potential cardio vascular patients receive statins.

Dental services

NHS England is calling for local health bosses to “recover dental activity towards pre-pandemic levels”. This has been followed by clashes in the House of Commons over Rishi Sunak’s wildly dishonest statement to MPs claiming that dentist numbers have increased, they have been given a new contract, and that more money has been put into dental services.

This has been condemned by the British Dental Association, whose response spells out the problems that Sunak and NHS England ignore: “The ongoing exodus from the NHS workforce saw 24,272 dentists perform NHS activity in England during 2021-22, lower than levels seen in 2017/18.

“The BDA does not consider recent tweaks to the discredited NHS system as a ‘new contract’, given formal negotiations on substantive change have yet to begin. These minor changes – which

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had no new funding attached – are unlikely to increase access or improve workforce retention.

"The budget for dentistry has been subject to a decade of savage real terms cuts, and with inflation at record levels the BDA estimate it would take an extra £1.5b a year simply to restore resources to 2010 levels.

"In August the PM pledged to "restore" NHS dentistry by ringfencing its funding, strengthening prevention and encouraging dentists to stay in the health service. … There is no evidence any element of the plan has been taken forward."

Indeed far from improving dental services, research undertaken by the BBC over the summer revealed nine out of ten practices in England were unable to take on new adult NHS patients.

Elective waiting times

NHS England moves relentlessly on, demanding an end to referral to treatment waiting times longer than 65 weeks by March 2024, and, according to the HSJ, now giving trusts just 20 days to book in dates for all 48,000 patients currently waiting over 78 weeks.

On cancer care, however, which most people would deem more urgent, the target is much more vague: "Continue to reduce the number of patients waiting over 62 days". In addition there is a requirement to speed up diagnostic services so that 75% of patients urgently referred by GPs for suspected cancer are diagnosed or given the all-clear within 28 days.

This will inevitably pile more pressure on to overloaded and under-resourced diagnostic services, which again have a remarkably vague target: "Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%."

NHSE makes clear that the aim is a 25% expansion in diagnostic capacity, and some of this at least has been funded, although only for the purchase of equipment and development of new Community Diagnostic Centres – leaving open the question of how staff are to be employed to work the kit and deliver the service: "£2.3bn of capital funding to 2025 has … been allocated to support diagnostic service transformation, including to implement CDCs, endoscopy, imaging equipment and digital diagnostics." (p12)

Maternity and mental health

Maternity services is the only area in which there is a specific mention of staffing numbers, with a requirement to fill more vacant posts.

Mental health services, which were given empty promises of increased numbers of staff, face six tough new challenges from NHS England.

The first is to move towards the national ambition for 345,000 additional individuals aged 0-25 accessing "NHS funded services" – clearly recognising that many of these services have been hived off to private contractors

NHS trusts also need to deliver a 5% year on year increase in the number of adults supported by community mental health services, and "work towards eliminating inappropriate adult acute out of area placements". The specific reference only to adult out of area placements underlines the continued gaps in provision of local mental health care for children and adolescents – where this is also a problem, but kicked into the long grass by NHSE.

On finance, trusts and Integrated Care Boards are required to deliver a "balanced net system" – despite widespread underlying deficits in trusts and ICBs, and the hugely ambitious targets for cash savings and "efficiencies" – many of which are admitted to be non-recurrent, and therefore concealing the scale of the financial challenge in 2023-2024.

The document: key details missing

Over and above the list of tasks, the NHS England guidance is as interesting both for what it leaves out and for what it says.

The document makes clear that "total ICB allocations [including COVID-19 and Elective Recovery Funding (ERF)] are flat in real terms with additional funding available to expand capacity." (p5)

It makes clear that limited extra capital funding will only be available to those who have least financial problems and best balanced their books: "Capital allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that deliver agreed budgets in 2022/23."

Given the constraints on NHS funding, it is especially galling for NHS staff to find that the one area that NHS England wants to expand is use of "independent sector providers," which must be "actively included" in local system plans (p11).

It's not until page 11, however that NHSE admits that hopes of balancing the books depend once again on "returning to and maintaining low levels of COVID 19" – a desire that has yet to materialise, with thousands of front line beds still occupied by Covid patients.

There are repeated references to documents that either don't appear at all on the NHS England website or have yet to be written, notably the "Revenue finance and contracting guidance for 2023/24," for which no publication date is given.

There is a tantalising promise that NHS England working with DHSC and the Department for Levelling Up, Housing and Communities "will develop a UEC (Urgent and Emergency Care) recovery plan with further detail … in the new year," (again no date). (p8)

The document calls (p9) for "increased referrals into Urgent Community Response (UCR)", but does not address the enormous geographical variation in levels of provision and performance, with nine of the 42 ICB areas (Derbyshire, Lincolnshire, Leicestershire, Herts & West Essex, Staffordshire, Cornwall, Cam-

bridgeshire & Peterborough, Bristol & North Somerset, and Dorset) registering minimal if any delivery of services in the most recent statistics.

NHS England goes on to promise another major policy document, the "General Practice Access Recovery Plan" – also due "in the new year". (p10) The 23/24 guidance refers to "the vision outline in the "Fuller Stocktake" – but no such document comes up on a search of NHS England's website.

It also refers to "the Cancer Alliance planning pack" (p12) which also yields no results on searching the website, although doing so reveals that the "NHS Cancer programme: Quarterly report overviews" began in 2019 but have not been published since 2021, and the page on Cancer Alliances has not been updated since it advertised "Cancer Alliance priorities 2019/20".

Another promised document is "a single delivery plan for maternity and neonatal services" … some time in 2023 (p13), and help for "ICBs to co-produce a plan by 31 March 2024 to localise and realign mental health and learning disability inpatient services over a three year period as part of a new quality transformation programme." (p15). So this might yield action by 2027.

People Promise

Even NHSE seems to have realised that they while they might be able to ignore the pay dispute taking place around them, they can't completely ignore the question of workforce. So the "to do" list and two brief sections of the pre-Christmas letter make reference to the "NHS People Promise," arguing that a "systematic focus" on this is the key to staff retention (p3).

For those who haven't seen the Promise, it makes bizarre reading in today's context. Obviously it has some perfectly reasonable aspirations and values: but Promise 2 reads:

"We are recognised and rewarded"

"A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution."

In practice staff are lucky these days to even get the "thank you": recognition of dedication and fair salary have not been seen for over a decade, and the government is so far standing firm against any attempt to change that

Promise 3 is headed: "We each have a voice that counts," and promises:

"We all feel safe and confident to speak up. And we take the time to really listen to understand the hopes and fears that lie behind the words."

Of course this is not true either: heavy handed central comms staff from NHS England are gagging those senior managers who might otherwise have the guts to speak up about the situation on the ground in particular trusts and services, whistleblowers are no more protected than they were 20 years ago, and staff face the threat of disciplinary action if they speak out publicly on their concerns for the quality and safety of services.

Promise 4 is again at variance with the experience of too many junior doctors, nursing staff on 12-hour and longer shifts: it states

"We are safe and healthy. We look after ourselves and each other. Wellbeing is our business and our priority – and if we are unwell, we are supported to get the help we need. We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology."

These words just take the breath away. This is the same NHS England that has just decided to pull the funding for mental health hubs brought in to support staff traumatised by the scenes they witnessed and the ways they had to work during the pandemic, even while hospital staff are being further stressed and scarred by the nightmare scenes in A&E departments and corridors, and ambulance staff are forced to watch blue light patients die in the back of ambulances as they queue to hand them over to hospitals.

This is the same NHS England that has seen the total bill for backlog maintenance needed to keep hospitals clean and safe and update clapped out equipment soar above £10bn, and knows around a dozen hospitals built in the 1970s with defective concrete planks are literally falling down, rehearsing emergency plans to evacuate patients if a ceiling collapses.

Nor is the technology right. Only a few weeks earlier the BMJ highlighted how failing IT infrastructure was undermining safe healthcare in the NHS.

NHSE know full well that this promise is not worth the webspace it is published on, and will simply infuriate any NHS staff who see it.

And as staff shortages bring a return to some of the worst excesses of demands on shattered junior doctors, and nurses report crying daily at the conditions they face each time they report to work, it is perhaps even more galling for many to read Promise 6:

"We work flexibly. We do not have to sacrifice our family, our friends or our interests for work. We have predictable and flexible working patterns – and, if we do need to take time off, we are supported to do so."

This may be true of some senior managers – and good luck to them. But it's all too clear that few staff at the front line of patient care would recognise this as their reality at work, or have any faith in a promise that it could be the situation.

If this is the best NHS England can offer as a hope to retain more staff, there are far worse problems coming down the line, with staff forced to fight to stop endless real terms pay cuts, an NHS bogged down with "flat funding," seeking "savings" rather than matching resources to needs, and promising only the most ludicrous fantasies of improvement for the next two years at least.

John Lister

Thumbs down for Ken Clarke's not-so-cunning plan

There's not likely to be a groundswell of enthusiasm for the old cigar-smoking beer-swilling former Chancellor Kenneth Clarke's idea of raising more revenue for the NHS by getting 'wealthier people' to pay means-tested charges for GP visits and hospital care.

His plan appears even to have upset the right wing Daily Mail, which headlined their report "Middle-class families could face 'modest' charges to see GP and have routine ops."

It's strange to see a Daily Mail reporter of all people point out that: "The two-tier idea goes against the very founding principle of the health service, in that treatment should be provided free at the point of delivery for all, whatever their means."

The Mail article also flags up the similar idea that has recently been raised and disowned in Scotland. But it would have also raised the hackles of some core Tory voters and Mail readers, by comparing a possible charging system … to that now paid by immigrants working in Britain! "A … potential way to create a two-tier NHS would be to create a special tax that the wealthy could pay to access the health service if the need arose.

"England already has a such a system in place for immigrants coming to the UK which could be used as a model. Called the immigration health surcharge, this sees anyone who immigrates to the UK to live and work charged £624 per year plus £470 per year for any dependents under the age of 18.

"… The charges end when a person leaves or becomes eligible to remain in the UK permanently and they choose to do so. Expanding such a scheme to Britons would be highly controversial to say the least."

What the Mail does not ask, however, is why would we want to even consider breaching two of the key founding principles of the NHS – its universality and its provision of clinical care fee at point of use – to raise more money, when it would be so much simpler just to make the tax system fairer and more inclusive by getting the wealthiest minority of billionaires, tax dodgers and super-rich to pay their share of tax?

General taxation could also benefit other public services such

as education, or even increase the miserable state pension.

Given that millions of people would not, at least at first, be paying the new NHS charges, to generate any significant contribution towards the £150bn-plus NHS budget they would have to be substantial – and therefore unpopular.

Clarke uses the analogy of prescription charges, which in England offer widespread exemptions, including means-testing to allow reduced costs for those on low incomes.

But prescription charges themselves are a classic example of a stupid way to raise money for health care – by creating a barrier for the poorest accessing the health care they need.

It is such a stupid system that in Wales, Scotland and Northern Ireland their devolved governments have scrapped prescription charges leaving only the English public still lumbered with them.

At the last count prescription charges, at £9.35 per item, paid on less than 10% of all prescriptions, raised just £615m towards a drugs budget of £11.5bn (less than 5 percent). It's a barely measurable share of around £150bn annual spending on England's NHS: and the damage that is done by deterring people on incomes just above the threshold to pay for their prescriptions could easily outweigh that.

Why have the Tories always been so fixated on taxing illness, and levying charges on the sick, even when it's likely to be their own core supporters? That is the triumph of ideology over common sense.

The charges would not affect the super-rich, who only come near the NHS if they need emergency treatment or complex treatment beyond the limited means of the private sector. The less wealthy may opt simply to insure against having to pay for NHS treatment – but obviously if the aim is to raise significant sums from these charges the definition of 'wealthy' would have to be widened to include tens of millions of "middle class" people – and the Mail fears.

So what might start as apparently getting a few fat, rich people to stump up extra cash for the NHS would swiftly degenerate into a major erosion of the principle of providing care on the basis of need.

It would potentially detach millions of people from their loyalty and affection for the NHS and push them into the arms of grasping insurance companies, who would be given a brand new chance to make profits from health – without offering any services.

It's important to recognise that the universal principle is a strength of the NHS: intelligent richer people know that without the NHS there is no emergency care, little if any maternity care, limited cancer care, and very limited mental health care.

Keeping the wealthy reliant upon and benefitting from the NHS is crucially important.

30 years ago Ken Clarke as Health Secretary gave us the internal market system and then soon afterwards as Chancellor he saddled the NHS with the excess costs of PFI. He has done too much damage already.

This proposal is as bad as the others: he should stick to playing his jazz.

John Lister

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

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

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

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

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

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