THE lowdown

Health news, analysis and campaigns.
NUMBER 21, March 30 2020

Informing, alerting and empowering NHS staff and campaigners

CCGs crack on with closure plan

The country is on lock-down, public meetings and events of all kinds have been cancelled into the autumn, and NHS England is busily not only revising its previous pressure to reduce bed numbers, but working with the army to set up massive new field hospitals.

But none of that seems to be standing in the way of the determination of three CCGs in South West London and Surrey to push through controversial plans to halve the number of front line beds.

The vague and evasive consultation document was due to end its consultation on April 1.

But when pressed by Merton council for a delay in view of the circumstances created by the Covid-19 epidemic, the CCGs have grudgingly agreed just a 5-day extension, to April 6.

This must mean that the CCGs are preparing to use the lockdown to push on with their plans, behind locked doors and with no troublesome meetings or public scrutiny to get in the way.

The plan was one of the six new projects to be funded by Tory ministers last year.

How many other plans are similarly continuing behind closed doors while the lockdown continues? Let us know at the Lowdown and we will keep a running tally of beds and services at risk.

Privatised cleaning for new Nightingale Hospital

As the NHS and the Army's joint project to convert London's ExCel into a 4,000-bed field 'Nightingale Hospital' takes shape, with the prospect of two giant "wards" of 2,000 beds each, the HSJ reports "major clinical and cultural tensions" in addition to the huge logistical challenge.

In addition to locating and setting up all of the equipment and supplies required to kick off with 500 beds and increase towards the 4,000 target, the NHS has to find ways to staff the unique hospital – and decide what its actual role is supposed to be.

For some it will come as a shock that the cleaning, portering and waste management services are to be contracted out to multinational corporation ISS, the company whose failure to pay domestic staff at Lewisham Hospital triggered an angry walk-out early in March.

A company press release on March 27 was headed "ISS is proud to support the new Nightingale hospital:" but it also made clear that many of the staff drafted in to take on the new contract will be taken from vital work on other NHS contracts:

"At this stage the workforce is being drawn from around the country, starting with contracts the company holds with the NHS. Additional staff will be recruited from other areas that are currently on furlough."

The decision to bring in a private company to carry out this work was not linked to their ready supply of available staff: and budget constraints are not an issue

So the decision to bring in a private company to carry out this work was not linked to their ready supply of available staff: and we know that the NHS has been told it can spend as much as is necessary to get through the crisis, so budget constraints are not an issue.

It appears that UCHL director Ben Morrin, who has been given the role as workforce lead has decided not to include the cleaning staff in the NHS team that is to take on the onerous and potentially hazardous work of keeping the hospital clean and safe for patients and staff, despite all the decades of evidence that in-house services deliver better quality services.

IN THIS ISSUE

3 months of government blunders and deception

Chronicle of a "national scandal"

John Lister

The seemingly daily interview sessions in which a minister stands in front of microphones and cameras to waffle, evade and lie their way through a succession of awkward questions, without giving a clear or concrete answer to any of them, have continued as the epidemic has gathered pace.

However the attempts to palm off journalists and the public with superficial claims and statements have proved increasingly ineffective, while the frustrations of the NHS staff, whose own lives are potentially being put at risk, have been voiced more loudly and effectively.

Time and again Matt Hancock, whose department assured us in February that the NHS was "extremely well prepared for coronavirus," has been seen to have lied and dissembled when asked about the extension of testing, supplies of personal protective equipment (PPE) for hospital staff, and delivery of ventilators to supplement the inadequate stocks.

Hancock's claim, made on BBC Question Time, that he was working with supermarkets to secure deliveries of food to vulnerable patients was denied by retail insiders and described as "totally made up".

Even the Daily Mail cast doubt on assertion that new ventilators could be in hospitals 'within days' when in fact manufacturers were warning that it would take a month to start large scale production.

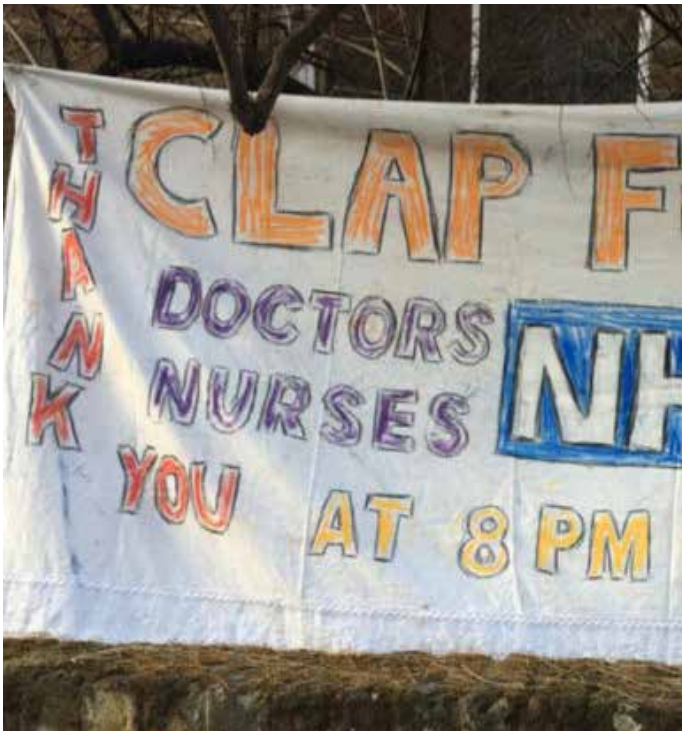
On March 15, Hancock denied that government policy included the development of "herd immunity" which would involve the infection of up to 60% of the population with the virus, insisting "Herd immunity is not our goal or policy," just days after the government's scientific advisor Sir Patrick Vallance had outlined exactly that policy alongside Boris Johnson, and explained it at length in a Sky TV interview.

Testing

Hancock has also given repeated false assurances that the programme of testing for the virus, central to the WHO proposals for containing the spread of disease, was being "ramped up," in the face of evidence that levels of testing have barely increased in weeks.

A recent Financial Times free to read report shows how the UK became one of the first countries to develop an accurate test after the virus details were published by the Chinese in January, but then charts how limited has been the British roll-out of testing. While South Korea showed how testing and a huge effort to track the virus and trace contacts of those affected had managed to 'flatten the curve,' in Britain no such effort has been made.

NHS staff are now promised testing from the last week of March – but only after some NHS trusts have had up to 50% of staff off work and self-isolating



The government announced on March 11 it was aiming to increase testing to 10,000 per day; on March 17 the government claimed it was working 'very fast' to roll out COVID-19 testing for frontline NHS staff, after doctors warned a failure to provide quick tests could deepen workforce shortages; on March 25 Boris Johnson promised to increase testing to 250,000 a day: but according to the Financial Times officials say it won't reach 25,000 until the middle of April, and the latest picture shows only 6,500 tests per day.

NHS staff are now promised testing from the last week of March – but only after some NHS trusts have had up to 50% of staff off work and self-isolating, unaware if they have the virus or just symptoms. A new "game changing" test for antibodies to show if people have had the virus is also promised: but as the FT points out it's still unclear when this will be widely available.

Ventilators

Ministers and their spokespeople have also clearly been lying over their long delays and failure to secure adequate additional supplies of ventilators, to ensure the NHS receives them in time. The dithering and delays go back to the early days of the outbreak in January, but

Chinese medics: many trusts have had problems getting much more basic PPE supplies.

also much more recent decisions that have denied the NHS a share of a bulk procurement of ventilators and protective gear:

Two weeks ago Britain decided not to join in joint efforts by the EU which combined an export authorisation scheme to prevent vital medical equipment leaving the bloc's single market and an accelerated procurement process to help member states secure ventilators and testing kits.

No 10 initially said it did not join these efforts because the UK was no longer a member state: "We are no longer members of the EU," the prime minister's official spokesperson told reporters early on Thursday. "We are doing our own work on ventilators and we have had a very strong response from business. We have sourced ventilators from the private sector and international manufacturers."

However after mounting criticism that the government was putting "Brexit over breathing", the spokesperson later changed the story completely, arguing that the UK had missed the procurement deadline due to a "communication problem" which meant the country was not invited to apply in time.

At least one of these versions must have been a lie.

A spokesperson for the European Commission has since dismissed the claim of any communication problems, and confirmed Britain is able to participate in "any joint procurement" during the 11-month Brexit transition period. MSN reports that "The procurement programme, initiated by the commission, uses the bulk buying power of the single market to get priority for ventilators and protective equipment – which doctors have warned are in short supply in the UK."

The first tranche of orders, which will go to 25 of the 27 member states, covers "masks type 2 and 3, gloves, goggles, face shields, surgical masks and overalls" – just what NHS staff are crying out for.

But this failure to grab an opportunity to ensure bulk provision of vital equipment is no stray story – it is part of an ongoing pattern of failure to make serious provision to fill identified gaps in NHS stockpiles that can make the difference between life and death.

Failure to grab an opportunity to ensure bulk provision of vital equipment is part of an ongoing pattern of failure to make serious provision to fill identified gaps in NHS stockpiles

The Financial Times reports that "A proposal that could have supplied the NHS with as many as 25,000 ventilators from China … went unanswered until it was too late, according to two companies behind it. Direct Access said it first contacted officials on 16 March with a plan to obtain manufacturing slots of 5,000 machines per week, which it conceived with Dubai-based Topland General Trading, as first reported by the *Nantwich News*.

"'Had quicker action been taken when we first contacted the client, we would now have supplied up to 15,000 ventilators with a further delivery of 10,000 within the next two weeks'," said Andy Faulkner, owner of Topland. "'And yet now, there are currently none on order

Continued overleaf page 4

URGENT APPEAL: we still need more support

A huge thank you to the individuals and union branches that have added their support to our appeal for financial support: but the cancellation of many labour movement events has made our campaign for resources to keep Lowdown much more difficult.

We hoped to fund the publication through donations from supporting organisations and individuals to avoid imposing a paywall that would exclude many who cannot afford to subscribe.

Having managed to raise enough money for our first year, and some more so far this year, the money is now running out and we urgently need more to keep going through the summer.

We know many readers are willing to make a contribution, but have not yet done so.

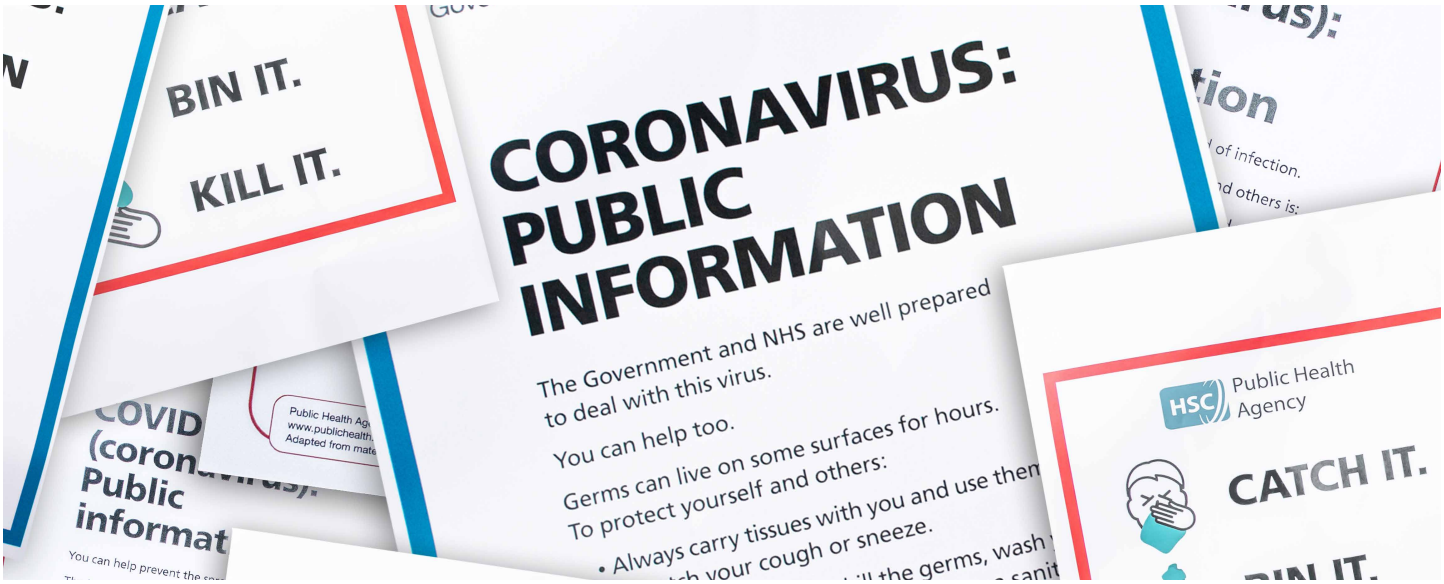
With many of the committees and meetings that might have voted us a donation now suspended because of the coronavirus, we are now asking those who can to give as much as you can afford.

We 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 can choose how, and how often to receive information, and are welcome to share it far and wide.

● **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 have any other queries or suggestions for stories we should be covering, contact us at *contactus@lowdownnhs.info*



National scandal

Continued from page 3

with lead times two to three months away'."

The *Financial Times* also reports another company, which asked not to be named, who said they had written to the business department at the start of last week offering to provide hundreds of ventilators for $15,000 each, but had received no reply. "My concern is that the government actions don't match their words," said one executive there.

World class systems

There has been a similar story of cynicism and deception over distribution of protective equipment. Health Minister Nicola Blackwood told *Pharmafield* magazine on February 12: "We have world-class systems in place to prevent supply problems and we are working closely with industry and partners to prevent shortages and ensure the risks to patients are minimised."

England's Deputy Chief Medical Officer, Jenny Harries, told a press conference on March 20, 2020: "The country has a perfectly adequate supply of PPE."

More than six weeks after Ms Blackwood's claim, and almost a week after the army was called in to help get the failed NHS distribution system functioning and forestall a threatened revolt by frustrated front line staff, we know that these assurances, too, were untrue.

Instead, front line staff in hospitals and GPs are still desperately trying to access the stocks of PPE they require, with some hospital departments sending out to DIY stores or begging donations of masks from school laboratories, and others improvising their own makeshift protective gear from whatever materials they can lay hands on as they wait in vain for deliveries from a chaotically privatised NHS Supply Chain.

Cost-saving versus safety

Worse still it's been revealed that in 2017, after an expert review recommended providing visors or safety glasses to all hospital, ambulance and social care staff, officials at the Department of Health, then headed by Health Secretary Jeremy Hunt, rejected the advice on grounds of cost, and refused to stockpile the quality of kit required to keep staff safe during the current crisis.

Shockingly, documents uncovered by TruePublica reveal that a 3-day exercise in 2016 to test the readiness of the NHS to cope with a pandemic of flu was the latest to show that the plans were inadequate, not least because of a lack of availability of sufficient ventilators: yet nothing was done to revise the plans, or fill the gaps that were exposed in provision of equipment.

"We have world-class systems in place to prevent supply problems and we are working closely with industry and partners to prevent shortages ...." – England's Deputy Chief Medical Officer Jenny Harries

TruePublica has also highlighted the decision on March 21 by the Johnson government to downgrade the classification of Covid-19, and – despite the fact that it has caused more disruption and more deaths already in Britain than any High Consequence Infectious Disease since World War Two – cease to regard it as a 'High Consequence Infectious Disease'.

As a result: "the British government has reclassified Covid-19 as less of a consequence than SARS (total global deaths recorded 774), MERS (total global deaths recorded 600), – along with Avian Influenza H7N9, H5N1, H5N6, and H7N7. Listed as High Consequence Infectious Disease (HCID) is even the Andes Virus Infection (possible one global death) which infected just four people in the UK with no known deaths."

Noting that the updated document ends with – "This guidance includes instructions about different personal protective equipment (PPE) ensembles that are appropriate for different clinical scenarios," TruePublica tries to guess the reason for this apparently irrational change:

"Has the government covered its back to stop legal cases against it for not supplying the correct safety equipment to frontline medics who die, given that many doctors are complaining of lack of PPE?"

Serial failures

Lancet editor Richard Horton has been consistently criticising the government's serial failures to heed international expert advice and early warnings, resulting in weeks of delay in taking basic steps. He argues:

"The NHS has been wholly unprepared for this pandemic. It's impossible to understand why.

"Based on their modelling of the Wuhan outbreak of COVID-19, Joseph Wu and his colleagues wrote in *The Lancet* on Jan 31, 2020:

"On the present trajectory, 2019-nCoV could be about to become a global epidemic…for health protection within China and internationally… preparedness plans should be readied for deployment at short notice, including securing supply chains of pharmaceuticals, personal protective equipment, hospital supplies, and the necessary human resources to deal with the consequences of a global outbreak of this magnitude."

Because this was not done, argues Horton, "Patients will die unnecessarily. NHS staff will die unnecessarily. It is, indeed, as one health worker wrote last week, "a national scandal". The gravity of that scandal has yet to be understood."

NHS England's deal a life-saver ... for private hospitals

John Lister

As Gary Neville and Ryan Giggs offer their hotels to NHS staff for free, and various companies donate hand sanitiser, equipment and food to help the NHS effort against Covid-19, a rather different approach can be seen among private hospitals, most of which have been effectively kept in business by treating over 500,000 NHS-funded patients each year, to fill what would otherwise have been numerous empty beds.

The private hospital bosses were delighted with the NHS England decision to block book 8,000 private acute beds.

Independent Healthcare Providers Network (IHPN) Chief Executive David Hare however was evasive on the cost of the deal, arguing was not possible to disclose its value because it was not yet known how long the arrangement would be in place, or what the NHS would use. But he told the HSJ all providers had agreed to "a fully transparent approach and to provide services at cost price."

Spire Healthcare, which runs 35 hospitals in the UK, told the Financial Times that the deal would provide it with "sufficient liquidity and financial stability during the Covid-19 outbreak," and that it would receive **"cost recovery for its services, including operating costs, overheads, use of assets, rent and interest less a deduction for any private elective care provided".**

The deal will work for minimum period of 14 weeks, and then on a rolling basis terminable by NHS England on one month's notice, Spire added.

£300 per bed per day

The *Mirror* however states clearly that the cost of the contract is £300 per bed per day, putting the cost of block booking 8,000 beds at £2.4m a day, and the initial 14-week contract at £235m.

The FT reports David Rowland, director of the Centre for Health and Public Interest, who points out that the deal would come as a relief to the private sector at a time of massive uncertainty because it would have suffered if all non urgent operations had been cancelled and consultants redeployed.

"Due to the focus on Covid-19 it is highly unlikely that private hospitals would be able to perform anywhere near the volume of elective operations that provide their main source of income.

"This is due to the fact that the anaesthetists and doctors who would carry out these operations are NHS employees and they will be expected to turn their attention to the fight against the coronavirus rather than carrying out operations privately."

Obviously the private hospitals were keen to emphasise (and quite possibly exaggerate) the numbers of staff involved in this first-ever deal on this scale. The Independent Healthcare Providers Network (IHPN) trumpeted:

"Nearly 20,000 fully qualified staff will be joining the NHS response to the pandemic, helping manage the expected surge in cases. The extra resources now secured by the health service will not only be available to treat coronavirus patients, but will also help the NHS deliver other urgent operations and cancer treatments."

Spire Hospitals expect to receive "cost recovery for its services, including operating costs, overheads, use of assets, rent and interest less a deduction for any private elective care provided"

Low productivity

Of course the fact that 20,000 almost entirely NHS-trained staff have been siphoned off into a low productivity, high cost private sector that according to analysts Laing & Buisson uses 9,872 acute beds, but treats an average of just 127 patients per bed per year (just over 2 per week) is one reason why the NHS has trouble recruiting the staff it needs.

The deal with NHS England is likely to make much more intensive use of 8,000 of these hospital beds across England, and it's claimed this would also make available "nearly 1200 more ventilators, more than 10,000 nurses, over 700 doctors and over 8,000 other clinical staff."

Many of the staff, as noted above, are already NHS employees working extra hours in private hospitals: so whether they are truly "extra" is hard to judge. What proportion of private hospitals – many of them very small, with no ICU facilities and geared only to uncomplicated elective surgery – are suited to treating Covid-19 patients is also open to doubt.

The Laing & Buisson figures (2018) show 197 of the 277 private hospitals are registered to take inpatients: 9872 beds shared between 197 hospitals averages 50 beds, but if the bed total is for all 277 hospitals the average size would be just 36 beds. Since we know a few private hospitals are much larger than this, it means some must be extremely small.

■ Meanwhile the NHS is also closing many of its own 1,142 private beds, to make them (and the staff allocated to them) available to help fight the Covid-19 epidemic.

Serious questions need to be asked after the crisis period subsides about the financial viability of those pay beds rather than simply allowing them to revert back to their normal pattern of partial use by limited numbers of patients, with no serious financial accountability.

Putting patients before profits?

John Lister

The Spanish government has taken powers under a royal decree to take over the management of private hospitals as part of its efforts to minimise he death toll from Covid-19, and the Guardian reports that this has promptly been done:

"In Spain, … the government announced sweeping measures allowing it to take over private healthcare providers and requisition materials such as face masks and Covid-19 tests. The health minister, Salvador Illa, said private healthcare facilities would be requisitioned for coronavirus patients, and manufacturers and suppliers of healthcare equipment must notify the government within 48 hours."

Cancelling operations

And while NHS England has reportedly had to pay a hefty £300 per bed per day to block book private hospitals to help tackle the Covid-19 crisis, across Europe it appears private hospital chains have been more ready to respond, cancelling elective work to make facilities available for the fight to combat the virus.

Private sector journal Healthcare Business International reports a German hospital advisor:

"The situation for German for-profit hospitals is highly unclear. In the main, they have now followed the advice of the Vereinigung (union) and dropped all elective work, so profits will erode.

"The government has given assurances that it will pay for capacity needed for COVID but probably this will not be very much. In my opinion, it would be completely politically unacceptable for such compensation to generate a profit margin. So margins have already dropped as electives are halted and if the government takes the capacity over there will be no profits for the duration."

In France, too, private hospitals have cancelled 75% of elective operations and dedicated 20-60 beds per private hospital for Covid-19 cases – around 4,000 beds.

In Italy, with all private elective operations cancelled weeks ago, HBI reports the private sector as a whole has provided 2,621 beds and 270 ICU for COVID-19, of which the largest private operator Gruppo San Donato has provided around 800 regular beds and 100 ICUs, and number two Humanitas 317 beds and 32 ICUs.

Private hospital association president Dario Beretta told HBI: "This is not the time for ideological and sterile confrontations. Lombardy health is one, united and supportive in the emergency that affects all citizens."

HBI sums up its overview of Europe warning that

"The next six months might see no profits for for-profit hospitals as electives are halted and all COVID-19 work is done at zero margin, as making a profit from COVID-19 will be viewed as politically unacceptable – though higher bed utilisation than for-profits usually have could offset that."

By contrast a British analyst discussed with HBI the financial benefits of NHS England's block-booking deal in Spire Hospitals, whose share price has been sliding downwards despite increased earnings, in the aftermath of the scandal surrounding its rogue surgeon Ian Paterson:

"Let's say there are suddenly thousands of new COVID-19 cases and the NHS needs to access all of Spire's capacity for those cases. You could make an argument that a private hospital working on an NHS tariff at 100% capacity is much better than doing PMI [private medical insurance] work at 50% capacity."

As the saying goes "war is terribly profitable": and even an apparently "cost-only" contract that keeps beds full and private hospitals ticking over nicely during the epidemic can prove a financial filip to Britain's private hospitals, which could emerge as one of the few sectors to survive the crisis intact.

"Margins have already dropped as electives are halted and if the government takes the capacity over there will be no profits for the duration."

Testing times

Europe's private sector laboratories have been largely eclipsed by the state-run services when it comes to testing for the coronavirus, according to private sector analysts HBI:

It quotes Synlab, which operates in Britain as well as across Europe: "Synlab says: "Testing for the Coronavirus is regulated by governments in most markets. That means that state-owned laboratories primarily test for the virus."

HBI concludes that this situation is unlikely to change "unless countries in Europe move to a wider strategy of community-based testing."

The private labs have faced particular problems. In France many of the 4,200 labs have complained that they can't obtain the chemicals they need or the protective equipment, both of which appear to have been largely bought up by the government. To make matters more complex in both France and Germany patients need a doctor's referral to access a private lab test.

The Spanish government has requisitioned the materials needed for testing, forcing Synlab to abandon its project there, while Sweden has outlawed private tests and independent labs have no mandate to test in Italy. In Poland and the UK most tests are being done by state hospitals, leaving "a small and dubious" private market of tests paid for out of pocket by individuals.

One example of this is the £120 rapid "COVID-19 home testing kit" being marketed by Randox, a company registered in Crumlin, Northern Ireland, which pays £100,000 a year to Tory MP and former minister Owen Patterson.

The firm claims on its website that it "has developed a revolutionary test for Coronavirus (COVID-19), the new strain of coronavirus. The only test in the world that can identify the lethal strain and differentiate between other non-lethal variants with the same symptoms."

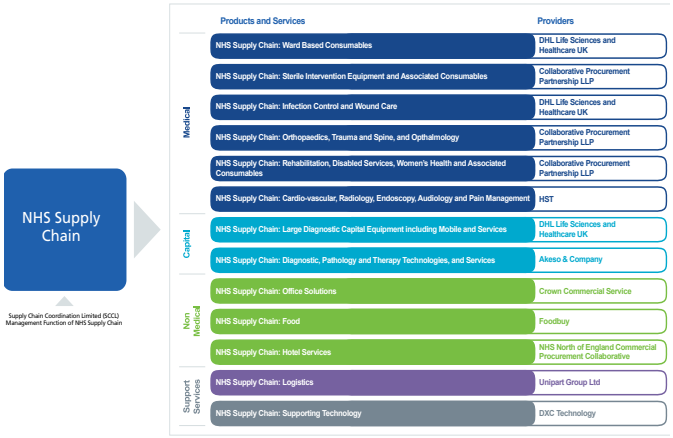
Buzzfeed which has revealed this story, notes that the same basic test has been bought up and sold on at even more inflated prices by other private sector operators in Britain:

"Summerfield Healthcare — which runs private clinics in the West Midlands — is selling the mail-order test for £249. Another company, Qured, a service that usually allows people to book face-to-face GP appointments, provides the kit for £295. …

"The Sunday Times published a story at the weekend about another company, Private Harley Street Clinic, that has been using Randox. The clinic has sold over 6,600 coronavirus test kits for £375 each to people who fear they have the illness, raking in millions, the newspaper claimed."

So as 700,000 public spirited individuals volunteer to help out the NHS and social care, as over 20,000 retired NHS staff put themselves in harm's way and joint front line staff in fighting to save lives and combat the virus, it's perhaps reassuring that Britain's private sector is sticking firmly to what it's best at: screwing a profit from sickness.

PPE delays – it's the Unipart way



John Lister

Chief executives and frustrated hospital and other NHS staff who are being left to treat potentially or actually infected patients without the right protective equipment may wonder who to blame: but at the centre of this ongoing fiasco, which has required the army to step in and try to get progress, is yet another botched Tory privatisation.

NHS Supply Chain is the organisation which should have been coordinating the distribution of the vital PPE gear, ventilators, supplies of sanitiser and other basics to hospital trusts, GPs and community health providers. It is manifestly failing in its task.

Who, then are NHS Supply Chain? Technically it is a holding company owned by the Secretary of State for Health and Social Care.

But in practice it is an immensely complex and dysfunctional web of contracts at the centre of which is Unipart, the one-time supplier of components to the motor industry, which won the £730m contract to take over the logistical contract from DHL back in 2018.

Since March last year Unipart Logistics has been tasked with delivering medical devices and hospital consumables (other than medicine) to NHS trusts, warehousing, inventory management, order processing and delivery, and a subcontracted home delivery service, which makes up 10% of the contract. So if they are not being delivered, it's down to them.

On commencing the contract, Frank Burns, MD of Unipart Logistics stated

"It has been a long held strategy for Unipart Group to contribute to the NHS on a national scale and being part of NHS Supply Chain provides this opportunity.

"We look forward to building on the existing strengths of the organisation and introducing further improvements and innovations by applying 'The Unipart Way' with a 'whole supply chain view' to help achieve NHS Supply Chain's priorities.

"We will bring to bear our group philosophy of understanding the real and perceived needs of our customers, serving them better than anyone else and through working in partnership with suppliers."

One year on, it's clear that many of their customers have now tearing their hair for weeks over the delays and failures of the 'Unipart Way' and their obvious lack of understanding.

On March 19, for example the HSJ reported that the company and "NHS Supply Chain" had actually been "'managing demand' for an increasing number of PPE and infection control products since the end of February to ensure 'continuity of supply'."

It appears that the company is deciding for itself what level of orders is acceptable, warning trusts that:

"Orders placed for excessive order quantities may be subject to automatic system reduction"

… and "Customers should be prepared to switch to alternative products if necessary."

One procurement lead told *HSJ*: "They aren't supplying enough, they aren't fulfilling orders. It's completely chaotic." Another said his trust had "just enough to manage for the time being."

HSJ reported central government had recently "eased some of its restrictions on supplies", although, "at time of writing, neither NHSCC nor the Department of Health and Social Care have responded to questions on what restrictions have been relaxed or on what products."

Not before time, NHS Supply Chain is also shipping FFP3 ventilator masks — crucial for protecting clinicians treating infectious patients — from the government's pandemic stockpile to trusts, although HSJ reports "some trusts have complained the allocations they are receiving are inadequate and unpredictable."

As the new system was launched it was claimed by the government that the whole clumsy package would generate savings of £2.4bn over five years.

13 contracts in the chain

Of course the blame might not all be due to Unipart: their contract is only the biggest of a batch of no less than 13 new national contracts which form the new "NHS Supply Chain," several of which are held by private companies. These contracts arise from splitting up the previous DHL contract:

"That contract has been disaggregated into four distinct functions: logistics; transactions services; IT prime to deliver supporting technology; and the 11 'Category Towers,' run by specialist providers."

These include DHL which lost the logistics contract, but now has three of the 12 smaller contracts, three more contracts are held by Collaborative Procurement Partnership LLP, and one each by management consultants Akeso & Company, Crown Commercial Service, Foodbuy, NHS North of England Commercial Procurement Collaborative, and IT specialists DXC Technology.

Confusingly the kit required to combat the Covid-19 epidemic appears to span three of the overlapping but apparently separate categories (which are for some obscure reason known as "category Towers") and covered by two different contractors:

- Ward Based Consumables
- Sterile Intervention Equipment and Associated Consumables
- Infection Control and Wound Care

Ominously, as the new system was launched it was claimed by the government that the whole clumsy package would generate savings of £2.4bn over five years.

Whether or not any such savings materialise we can only speculate at this stage, but if those savings are at the expense of a confused system of delays and incompetence that puts the lives of staff and patients at risk, few in the NHS will believe it is a price worth paying.

Now you see them, now you don't …

The case of the missing beds

John Lister

During the election Labour challenged the Conservative Party's record of cutting back hospital beds, pointing out that the number of beds had fallen to the lowest-ever level, 127,225 – a 10% drop from the figure for the same quarter in 2010.

Out of this total 100,406 are in general and acute hospitals, down from 108,349 in in 2010 – a fall of 7%.

Over the same period mental health beds have been cut by 21% -- from 22,929 to just 18,179.

Of course these reductions help explain the chronic bed shortages, delays and congestion of NHS A&E departments at peak times (not just winter any more) and underline the extent of the unpreparedness to tackle the challenges of the Covid-19 epidemic, which is stretching even better-resourced health systems in Europe.

In the scale of things the recent cutbacks have been relatively small-scale and slow.

1982 figures

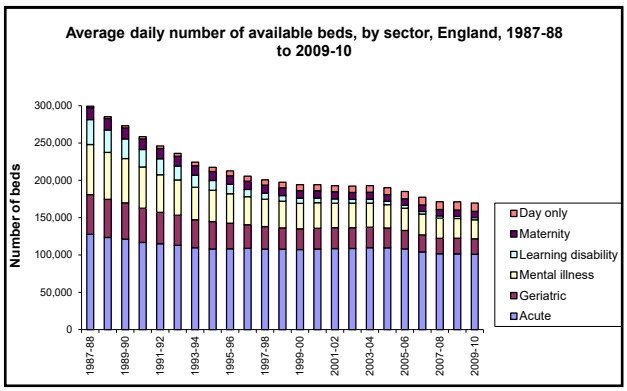
Almost 30 years ago, in 1982, the book of Department of Health statistics on *Bed availability for England*, which was only published once a year rather than the current quarterly figures, shows the total number of beds was a massive 348,104, with 199,181 general and acute beds, 83,831 mental health beds and 46,983 Learning Disability beds.

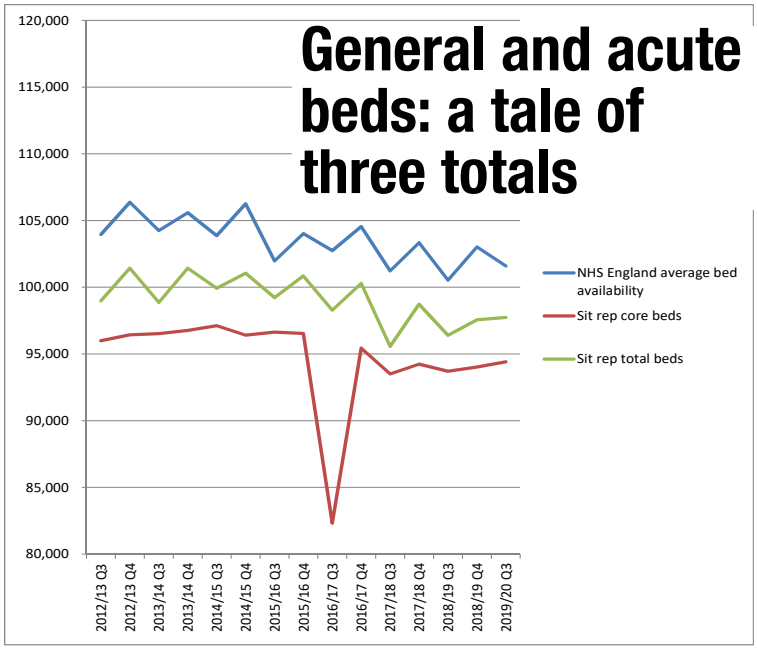
Over the decade to 1992 those numbers plunged – the total fell over 30% to 242,356, general and acute bed numbers fell 21% to 157,201, mental health beds were slashed by 40% to 50,278, and LD bed numbers were more than halved to just 21,107.

Underlying these and subsequent changes were a number of factors including:

● the first moves towards closing the large mental health asylums and hospitals for LD patients – with some less than positive results in the early-mid 1980s;

● a rising proportion of operations performed as day surgery (negligible in 1982),





30 years ago, in 1982, Bed availability for England showed a massive 348,104 beds, with 199,181 'general and acute' beds

● improved drugs to relieve or treat some problems that previously required surgery

● and reduced length of stay for surgical patients as a result of improving techniques and anaesthetics with fewer side effects.

However the extent to which these factors apply to current day bed closures is questionable and limited.

Of course we must remember that in the 1980s the NHS was run by the hard-line Thatcher government, under-funding the NHS in their attempts to force through "efficiency" measures and closures of beds and hospitals.

Natural limit

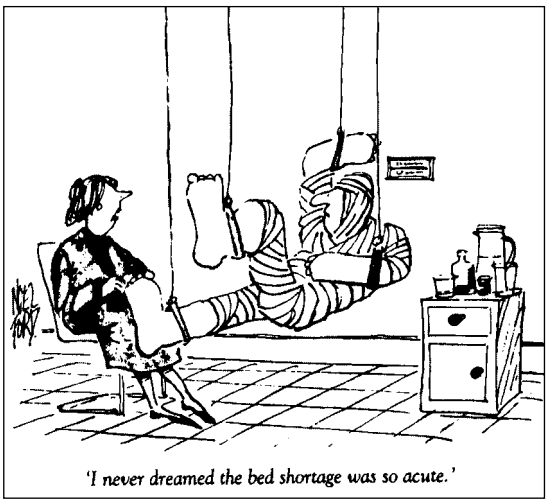
Eventually a natural limit was found, and from 1997 to 2005 the rate of closure of general and acute beds virtually came to a halt, before a sudden step down, and then three more relatively stable years before 2010.

There have been brief pauses in the decline that has generally continued since 2010 as NHS chiefs tried to ensure sufficient beds were open to address periods of peak demand.

But now the HSJ has reported that NHS general and acute bed capacity at a lower number than these official figures have yet reached:

"NHSE announcing a drive to free up around 30,000 of the service's overall 98,000 acute and general beds by a range of measures including postponing non-urgent operations and speeding up discharges."

NHS boss Sir Simon Stevens gave the same



'I never dreamed the bed shortage was so acute.'

figure when he spoke to the Commons Health Committee on March 17 – 3,500 fewer than the latest quarter's NHS statistics would suggest.

It appears that the figures is based on the total number of "core" front line beds available, and any additional "escalation beds" in use to address increased pressures as published in "winter sit rep" reports each winter since 2012.

These are daily figures and fluctuate considerably, but they have been taken seriously as working figures on which the NHS actually bases its decisions.

Core bed puzzle

But as the 98,000 figure shows, these numbers are also a puzzle: because at no point does the number of core beds provided, or the grand total of core beds plus escalation beds, add up to the published numbers of general and acute beds in Quarters 3 and 4 covering the winter period, when we know more beds tend to be opened up.

The graph opposite (compiled from Sitrep reports, taking the figures from December 1 and February 1 of each year, compared with the quarterly reports of availability of beds open overnight to admit potential emergencies) shows the size of the discrepancy.

The thing is, if these figures are at such variance, which set of figures gives a true picture? If NHS England reverts to the sit rep figures, what is the value of the Department of Health's figures, which are consistently different?

What factors might explain the gap? As the hunt goes on for ways of opening up more NHS capacity to deal with the Covid-19 crisis, it would help if the NHS at least knew with any consistency how many beds it has available, as a benchmark for how many more it requires.

■ NB in Quarter 3 2016 sit rep figures there appears to have been a meltdown of NHS calculations, since not only does their appear to be an abrupt plunge in beds, but the numbers of core beds plus escalation beds do not add up to the stated total. Four years on, it is surprising nobody seems to have sorted out that confusion.

Clearing the decks for Covid-19 influx

The *Health Service Journal* headline says it all: "Trusts told: Forget the rules, get people out of hospital," as NHS England hurriedly attempts to catch up with the brutal impact of a virus on hospital services.

The report, on March 23 notes the blunt instruction:

"Health and care organisations have been ordered to take radical measures to speed up discharges and help free up 15,000 beds by the end of the month.

"The drastic measures include suspending all eligibility and funding decisions from the hospital discharge process and temporarily scrapping continuing healthcare assessments — a move which requires legislative changes but hospitals have been broadly told get on with anyway.

"… One senior policy expert told HSJ the guidance "basically amounted to orders which say: whatever it costs, get people out of hospital. Don't worry about the rules, just do it."

The reference to extra costs is because the NHS is having to fully fund the cost of new or extended out of-hospital health and social care support packages, now that the statutory duties of councils to support vulnerable patients discharged from hospital have been suspended.

(The Coronavirus Bill published on 19 March effectively changed the rules to downgrade the duties of local government social services to assess and meet eligible needs of adults and carers to "powers" – i.e. no legal obligation – unless a failure to provide support would a breach an individual's human rights.)

However in many areas the problem will be an absence of sufficient available care, almost none of which is now publicly provided: where this is the case it's hard to see what will be done to support patients who are freshly deemed not to need hospital beds.

The HSJ reports unease and concern that to empty out such a large number of patients in such a short time is an impossible task.

ITV has reported that some hospitals have already opted to cancel all cancer surgery, going much further than NHS England's call to cancel elective operations from April 15 as they aim to clear another 15,000 beds in readiness for the expected tsunami of Covid-19 patients as the pandemic wave continues to rise.

When the crisis level subsides it will be important to check out the consequences for the thousands of patients whose care has been disrupted in this way to ensure that in any future such moves the toll of lives shortened and the suffering of the patients displaced is taken into account.

Lessons from the past
Can anything good come from Covid-19 crisis?

John Lister looks back at the mass clearance which aimed to empty 100,000 beds in days as part of the war preparations in 1939, but which overshot the mark – and took huge risks with public health.

NHS England's decision to order a rapid evacuation of 15,000 beds, driven from the top down, is unprecedented in normal peacetime: the nearest – much more traumatic – equivalent goes back to before the NHS existed.

The chosen methods in 1939 were:

- Clearance of patients from some existing hospitals.
- Crowding beds together and by providing additional beds in some existing hospitals.
- Improving ("up-grading") many hospitals through the provision of surgical appliances and other equipment.
- The erection of new accommodation in the form of hutted annexes or hospital hutted units.

It was the first of these that was the biggest problem: according to Richard Titmuss:

"The Government had hoped to find about 100,000 beds for casualties by turning out the sick, but it seems that the hospitals interpreted their instructions so rigorously that about 140,000 sick were, in fact, sent home. … Included in the figure of 140,000 were about 7,000–8,000 tubercular patients 'cleared' from local authority sanatoria, representing nearly thirty percent of all those receiving residential treatment at the time."

"… Patients in an early operable stage of cancer were sent home untreated; expectant mothers were refused admission for what were likely to be difficult and dangerous confinements; children in plaster of paris were deprived of the care they needed; bedridden patients—the arthritic, the diabetic and heart cases—were discharged to the care of relations, heedless of the fact that these relations might now have evacuated, leaving the house empty; highly contagious tuberculosis patients were sent to crowded homes with young children, perhaps to die, perhaps to infect their families."

Included in the figure of 140,000 were about 7,000–8,000 tubercular patients 'cleared' from local authority sanatoria, representing nearly thirty percent of all those receiving residential treatment at the time.

No proper records were kept to show what happened to those people discharged in this way.

In today's much more closely scrutinised NHS with wide-ranging data online it's unlikely that this will happen now, but it is important to keep track of the aftermath of today's desperate measures.

Once the patients had been sent home in 1939 the beds were kept free for an expected influx of civilian and military casualties from the war, so access for any other medical needs was drastically reduced:

"In addition, therefore, to the sick who were sent home, some of whom were 'wholly unfit people' and should not have been discharged, there was the problem of existing waiting lists at voluntary hospitals, tuberculosis sanatoria and other institutions."

The problem was even greater because more beds were made available in voluntary hospitals than the Government had expected, and all of these were to be paid for – whether they were utilised or not.

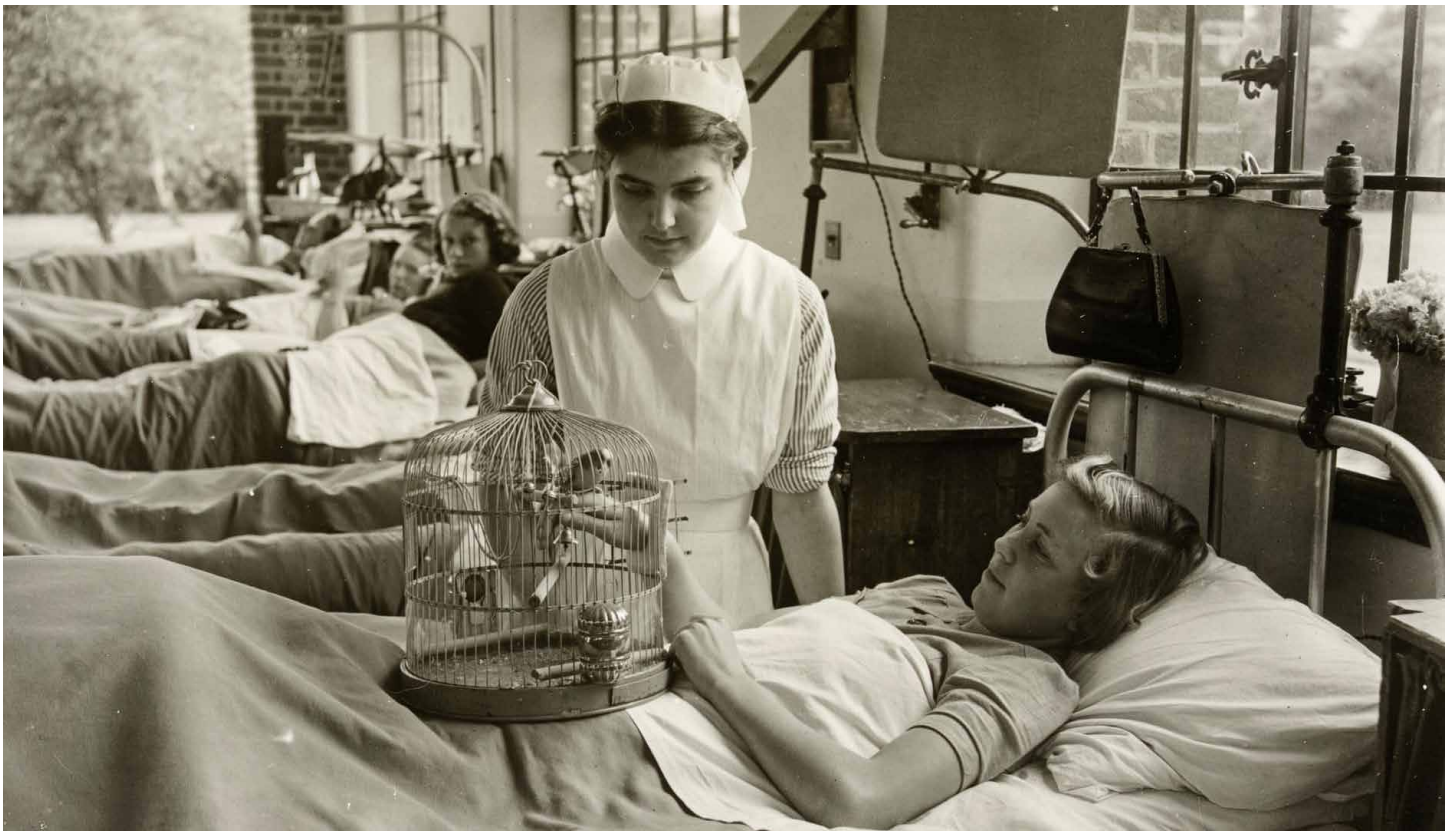
Voluntary hospital bosses in particular were more than happy to take the money for doing nothing, but keeping so many beds empty meant the hidden waiting list for a hospital bed more than doubled to 250,000.

Unlike now, when we know insufficient beds will be available to deal with the spread of the virus, in 1939 the need for beds had been considerably overestimated. Titmuss argued:

"After six years of war, after the blitz of 1940–1, the later bombings, the flying-bombs and the rockets, the total number of civilian air raid casualties treated in hospitals from beginning to end was roughly forty percent less than the number of sick people turned out of hospitals in about two days in September 1939."

However despite these harsh measures some of the preparations for war and the way services were delivered during the war were crucial in shaping the NHS legislation in 1946.

This is not unusual: as Titmuss pointed out, the Crimean War, through the work of Florence Nightingale, led to the creation of the nursing



profession; health defects discovered among recruits for the Boer War stimulated public health measures including the provision of school meals and a school medical service; and concern for the care of mothers and young children in World War One led to the establishment of the Ministry of Health.

Despite a Gallup poll in 1939 showing 71% of the public favoured making hospitals a public service supported by public funds, progress towards a national, tax-funded health service as WW2 approached was held back by the Treasury, which "clung tenaciously to the principle that ratepayers should bear at least a part of the cost of the medical care of their neighbours injured by air attack".

There was also the problem that

"The dominant feature of the pre-war situation was the existence of two distinct and contrasting hospital systems—voluntary and municipal. Both had grown up without a plan. Their origins and histories were dissimilar; they were differently organised and financed and, in some respects, they catered for different sections of the population."

No hospitals were controlled by the Ministry of Health, which had a purely advisory role and until 1939 little awareness of the poor state of both hospital systems.

More than half the hospitals and two thirds of the beds were in municipal hospitals, the rest under 'voluntary' management which was furiously opposed to any control over them by government and especially by local government.

One thing they had in common was both voluntary and municipal hospitals were old and lacking in resources.

"Two-thirds were built before 1891 and nearly a quarter before 1861. Many lacked diagnostic facilities, pathology, radiology and operating theatres while catering and heating required urgent attention.

"At one London hospital, the legs of the cots in the maternity department stood in tins of oil to discourage the cockroaches from crawling up!"

Most of the voluntary hospitals were small, not dissimilar in size from today's private hospitals: only 75 general (all-purpose) voluntary hospitals had more than 200 beds. Over 500 had fewer than 100 beds, and over half of these had fewer than 30.

The smaller voluntary hospitals also behaved not unlike today's private hospitals in limiting themselves to the less complex patients, and passing on any they could not or chose not to handle to the public sector. Titmuss notes a report by what is today's King's Fund:

"voluntary hospitals exercised 'their discretion over the admission of these patients (the chronic sick) and having admitted them transfer them to municipal hospitals'.

"During 1935–7 some 27,000 patients were transferred by voluntary hospitals to general hospitals provided by the London County Council."

This is one reason why, while they wanted and needed handouts of public money to keep going, the voluntary hospitals were also desperate to avoid any scrutiny or accountability from local or central government.

No hospitals were controlled by the Ministry of Health, which had a purely advisory role and until 1939 little awareness of the poor state of both hospital systems.

Despite this, the war preparations forced a massive upgrade:

"The adaptation and improvement of hospital buildings, including the installation of operating theatres, X-ray rooms, laboratories, dispensaries and stretcher lifts, and the improvement of sanitary and kitchen facilities, lighting and heating. By the outbreak of war about 150 hospitals had been selected for this work of upgrading, and much of the essential engineering had been done, but more than half the programme remained to be completed."

It was a huge effort:

"Nearly 1,000 completely new operating theatres were installed by October 1939. By the same date, some 48,000,000 bandages, dressings and fitments had been ordered. Close on a million surgical instruments were said to be wanted. The estimated number of artery forceps required represented, for instance, over thirty years' demand for the whole country."

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Learning from the past

Continued from page 11

By later 1941 an extra 80,000 beds had been added, funded by central government.

The emergency preparations also created an emergency public health laboratory service, and the expansion and improvement of pathological laboratories in many areas of the country, and the first blood transfusion service, to collect and store blood, beginning in London in 1939.

Linking up

The new Emergency Hospital Service and an Emergency Medical Service was introduced as soon as war broke out, to link the municipal and voluntary hospitals and provide a team of doctors.

Central funding of the voluntary hospitals and 60% of the costs in the municipal hospitals gave the government a right of direction over both for the first time.

As Nick Timmins writes in his *Five Giants* study of the birth of the welfare state, even though the elderly remained excluded:

"As the war progressed, free treatment under the emergency scheme had gradually to be extended from direct war casualties to war workers, child evacuees, firemen and so on until a sixty two page booklet was needed to define who was eligible. … Wartime proved that a national health service could be run."

It had also proved that the old system could not deliver what was needed, and it was clear that the voluntary sector could not continue on its traditional basis after the war.

The divisions between the two under-resourced hospital systems had been broken down, and could not realistically be re-erected.

The old system could not deliver what was needed, and could not continue after the war.

NHS historian Geoffrey Rivett argues that:

"The Emergency Medical Service, more than any other single factor, can be held responsible for the form and pattern of hospital organisation which emerged in London. … Doctors and nurses for the first time moved freely between the voluntary and the municipal hospitals, seeing the problems each faced. The experiences of teaching hospital staff and students who were drafted to municipal hospitals, where standards of clinical care often left much to be desired, helped later in the acceptance of the National Health Service."

Future prospects: what should we learn?

We can expect when the Covid-19 crisis eventually subsides, similar wider questions will be asked to those that helped Bevan shape the NHS after the war.

Why, for example, since it was apparently so simple to do, did it take a global pandemic to persuade ministers to release proper funding for the NHS, after a decade of unprecedented austerity had slashed bed numbers and restricted services?

Clearly we should resist any reversion to the artificial, austerity-driven limits now they have been set aside.

NHS England had already called a halt and partial reversal of the continued reduction of front line acute bed capacity, and has also paused any implementation of its deeply flawed Long Term Plan, which was written to comply with financial constraints.

But doesn't it make sense for the plan as a whole to be junked, now the situation has completely changed since it was written?

Scrap the market system

NHS England has also taken powers to override local CCGs and drive the NHS from the centre: the payment by results system has also been set aside. These are key elements in the market system established by the disastrous Health and Social Care Act in 2012.

Since so little of the Act is being enforced, it surely makes sense to scrap it altogether, along with the wasteful division between purchaser and provider that has added bureaucracy since 1990 and fuelled privatisation of clinical care since 2000.

Private contractors remain as providers of non-clinical support services and of clinical care – but their quest for profit from the public purse stands in stark contrast to the collective effort, dedication and sacrifice of front line NHS staff putting their health at risk dealing with the virus.

Most blatant of all are the support service contractors ISS whose staff resorted to strike action at Lewisham Hospital when they had not been paid, and who had still not paid up two weeks later as the epidemic has taken hold.

When the crisis subsides the fight must be stepped up to eliminate these companies which contribute nothing but impede the work of our most prized public service.

Private hospitals

Unions and campaigners are also challenging the wisdom of NHS England forking out a reported £2.4m per day to block book 8,000 private hospital beds to help make up for the 10,000-plus acute beds that have closed in the NHS since 2010, **rather than the government requisitioning or nationalising these resources – or at least those bits of the private sector that are useful to the NHS.**

From the chaos and confusion, ministerial bungling and lies, the crisis measures and the lessons learned, it's possible to chart a future way to an improved, fully-funded, publicly owned, provided and accountable NHS.