THE lowdown

Health news, analysis and campaigns.
NUMBER 23, April 27 2020

Informing, alerting and empowering NHS staff and campaigners

Tuesday April 28 International Workers' Memorial Day 11am

Stop the Pandemic in the Workplace!

Health unions UNISON and Unite, with Royal Colleges of Nursing and Midwives and the TUC have called for a minute's silence at 11am on Tuesday April 28 to remember the workers who have died because of COVID-19.

28 April is International Workers' Memorial Day, a time each year to remember all those who have died because of their work – and with so many workers now in the coronavirus front line, the IWMD slogan "Remember the dead, Fight for the living" has never been so crucial.

The health unions collectively represent more than a million NHS and public service workers, including porters, refuse collectors and care staff.

UNISON general secretary Dave Prentis said it would be "the ultimate tribute to remember workers who've lost their lives and put themselves in harm's way to keep us safe and vital services running.

"Thousands of key staff are on the frontline while the rest of us are in lockdown. That's why we've issued this call for the whole country to take part and remember the sacrifices they've made. The best tribute we can all pay them is to stay inside to protect the NHS."

Carers

Thousands more workers across the UK are caring for those suffering from COVID-19 or delivering vital public services that are vital for us all – potentially putting their own safety and even their own lives at risk. In many cases, these workers know that, by simply doing their jobs, they are putting themselves at risk.

Tragically, some of these workers have already died. In some cases, more could have been done to protect them, whether by better enforcement of social distancing, looking after workers with underlying health conditions or provision of adequate personal protective equipment (PPE) to keep them safe.

Unite also argues that "Workers are risking their lives every day, while many are still attending work ill-equipped and without necessary safety measures in place. We could not have a starker reminder of the important role of trade union health and safety reps in saving and protecting workers' lives."

Full public inquiry needed!

The TUC is demanding a public inquiry into the "grotesque failure to provide frontline workers with adequate personal protective equipment"

TUC call for inquiry

The campaign to ensure there is a full investigation of the way the crisis has been handled by the government, to give the UK one of the highest Covid-19 death tolls in Europe, has been stepped up.

The TUC is demanding a judge-led public inquiry by the end of the year into the "grotesque failure to provide frontline workers with adequate personal protective equipment (PPE)."

The TUC says that in order for the same mistakes not be made in the future the inquiry must look at:

- Why there were delays in the planning for and delivery of PPE.
- Whether guidance about the need for PPE in diverse workplace settings was timely and robust.
- Whether staff were put under pressure to work with inadequate or out-of-date PPE; and if so why.
- Whether staff were threatened with disciplinary action for raising concerns about the lack of PPE; and if so why.
- Why the NHS, social and residential care and other workplace settings have struggled to source PPE from suppliers.

It can't come a moment too soon.

IN THIS ENLARGED 16-PAGE ISSUE

Testing – from "ramping up" to unresolved fiasco

John Lister

Matt Hancock's sudden conversion on April 23 to the cause of mass tracing of contacts of people infected by Covid-19 and commitment to recruit and train upwards of 18,000 people to begin this process "within weeks" is a belated victory for the public health professionals who have been screaming the need for this ever since contact tracing was abandoned in early March.

But the failure for so long to track and trace and to build the networks necessary to do this effectively has contributed to the spread of the virus and prolonged the lockdown of the economy.

Following on the exposure of the chaos and broken promises on supply of personal protection equipment (PPE) to NHS and social care staff, this additional failure of government policy is moving centre stage, as the deadline to hit the target of 100,000 daily tests for the Covid-19 virus is just a week away, with only around 23,000 tests being delivered, despite claims of capacity to test up to 50,000 daily.

As this ***Lowdown*** article is completed (April 24) despite initial plans for "up to 50" drive through testing centres to cover the whole of England, and plans now announced to expand from 31 centres to 48, there is no definitive list published by the Department of Health and Social Care or by Public Health England of centres planned or functioning.

Vague

A vague low-res map has been produced for those who can find it online, showing that of the actual centres established just one is in Wales, three each in Scotland and Northern Ireland, leaving just 24 to cover the whole of England, with huge areas lacking any testing centre.

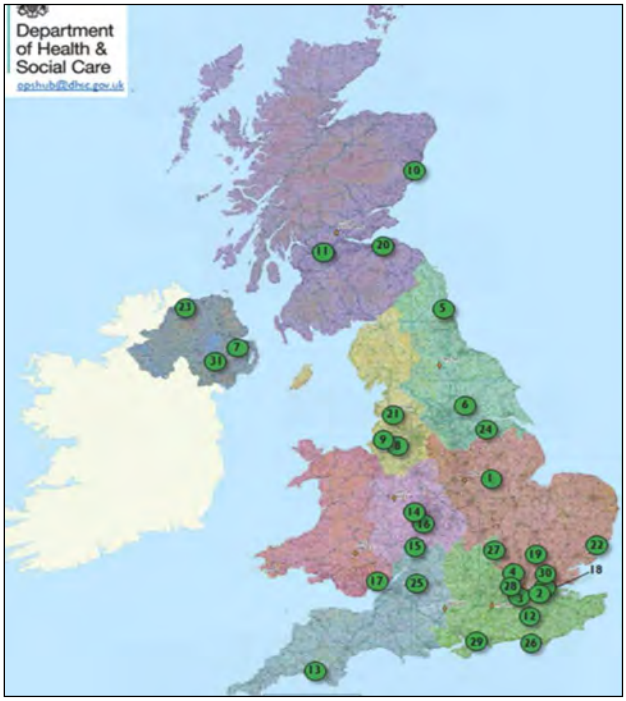
And people attempting to book themselves a test are promised a chance to choose where to be tested as they wade through the complex online process.

Meanwhile the Daily Mail has been highlighting the fact that many of those that have opened have few if any punters to test, not least because of the difficulties of getting to and from the test sites, while the Guardian has reported "severe failings" at the Chessington World of Adventure site, run by Deloittes.

Promises to "ramp up" testing to 10,000 tests per day were made by NHS and Public Health England on March 11 along with a commitment to increase the number of testing centres across the country, "to help people get care quickly or have their mind put at ease."

But the following day the government announced that its early work to track and trace everyone suspected of having the virus – the proven public health approach – was to be ended, and any attempt to keep track of infection was abandoned, while schools remained open, and mass gatherings were allowed to continue to the weekend. The government's chief scientific advisor Sir Patrick Vallance put forward the notion of building up "herd immunity".

A week later (March 18), with tests only running at around 4,000 a day, a government press release announced that testing would increase to 25,000 per day within four weeks, along with claims that Boris Johnson and Matt Hancock had "promised industry leaders that they would be given whatever support they need to help government increase testing capabilities across the country."



This vague low-res map is the nearest thing to a list of test sites

A common theme to most of the larger sites is that they are difficult or impossible to access by public transport and appear entirely geared up for car drivers.

Best in the world

The press release quoted Matt Hancock's immodest claim that "We are already among the best in the world for coronavirus testing and today we are launching a national effort to increase our testing capability even further." It's not sure which other countries in the world Hancock was referring to.

But on March 31, almost 3 weeks after the initial promise was made, a comment article in the Metro asked the obvious question "where are coronavirus testing facilities?"

It appears that the most definitive list they could offer was a list of ten centres, eight of which were in England, three of them in London, plus one each in Wales (Swansea) and Scotland (Edinburgh). The rather curious list included apparently small scale sites in Harpenden in Hertfordshire and Easingwold in north Yorkshire, and the article noted that centres had opened in Shrewsbury and Wolverhampton … only to close again, as a result of "government advice".

A common theme to most of the larger sites is that they are difficult or impossible to access by public transport and appear entirely geared up for car drivers. The huge areas of the country with no local access to a testing centre would be faced with a stark choice of long and arduous car journeys – or no test.

Referral

The Metro also stressed that members of the public would not be tested at the centres without a referral – to be made by employers. The next day the Sun headlined on "chaos" at testing centres, with long queues in Wembley (IKEA) – and little if any activity Chessington World of Adventures, with staff, including those told to attend after ringing 111, being told they could not be tested without emails specifying a date and time.

Despite this unpromising start Matt Hancock went on to announce in another press release (April 2) that "The UK will carry out 100,000 tests for

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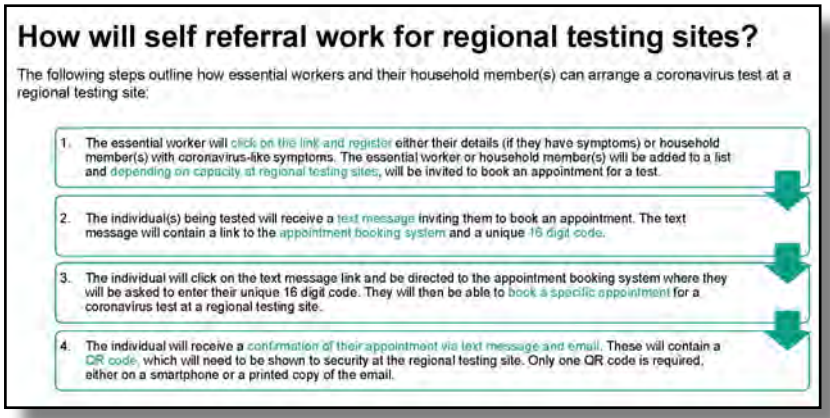

How will self referral work for regional testing sites?

The following steps outline how essential workers and their household member(s) can arrange a coronavirus test at a regional testing site:

1. The essential worker will click on the link and register either their details (if they have symptoms) or household member(s) with coronavirus-like symptoms. The essential worker or household member(s) will be added to a list and depending on capacity at regional testing sites, will be invited to book an appointment for a test.
2. The individual(s) being tested will receive a text message inviting them to book an appointment. The text message will contain a link to the appointment booking system and a unique 16 digit code.
3. The individual will click on the text message link and be directed to the appointment booking system where they will be asked to enter their unique 16 digit code. They will then be able to book a specific appointment for a coronavirus test at a regional testing site.
4. The individual will receive a confirmation of their appointment via text message and email. These will contain a QR code, which will need to be shown to security at the regional testing site. Only one QR code is required, either on a smartphone or a printed copy of the email.

coronavirus every day by the end of this month."

As with PPE, where several reorganisations have taken place as promises were broken and the system was obviously failing, a new figurehead was also brought in, presumably to take the blame when Hancock's foolhardy promise is not delivered. Professor John Newton the Director of Health Improvement for Public Health England, was appointed as "testing coordinator" to "help deliver the new plans and bring together industry, universities, NHS and government behind the ambitious testing targets."

Hancock also revealed a vague and repetitive "five pillar plan":

- Scale up swab testing in PHE labs and NHS hospitals for those with a medical need and the most critical workers to 25,000 a day in England by mid to late April …
- Deliver increased "commercial swab testing" for critical key workers in the NHS across the UK …
- Develop blood testing to help know if people across the UK have the right antibodies and so have high levels of immunity to coronavirus;
- Conduct UK-wide surveillance testing … and
- Create a new National Effort for testing …

The obvious common fact of all five pillars is increased testing. But the growth has been slow and uncertain, not helped by constant top-level self-deception and PR spin.

Every patient …

On April 3, as complaints grew from NHS staff unable to get tests and therefore forced to self-isolate and miss work, Public Health England boss Duncan Selbie made an improbable claim: that "Thanks to PHE's scientific capability … every hospital patient that requires a test has received one."

Selbie, apparently unaware of the 100,000 daily target set the day before by Hancock, went on to claim that "we … are well on track to reaching 25,000 tests per day – or 750,000 tests per month – by the end of April."

On April 6 NHS England's medical director for primary care, Dr Nikki Kanani said testing for primary and community services was now being organised at a regional and system level: "so an STP or ICS level – and the testing is now being delivered through both a combination of NHS trusts and PHE."

However there is little or no evidence on their websites of this being taken on by STPs, ICSs or hospital trusts. STP websites are notable for being virtually derelict, with little if any update since the end of last year. ICS sites seem to offer no information on testing.

A further government press release on "getting tested" for Covid-19, updated on April 17 displays a long and repetitious list of categories of people who they are "now testing": the list includes

All NHS and social care staff "including hospital, community and primary care, relevant staff providing support to frontline NHS services, and voluntary workers"

- Police fire and rescue services
- Local authority staff
- Staff working in children's care
- Defence, prisons and judiciary staff
- "Other frontline workers as determined by local or national need." Examples include:
- "testing infrastructure workers (such as laboratories); workers in the funeral industry and coroners; and frontline Home Office and Border Force staff."

The press release states that "Employers of frontline workers will be provided with information on how to make an appointment for their staff through their local resilience forum … their associated national department or agency, or directly through the Department of Health and Social Care."

However, while testing for patients and NHS workers may be provided in some hospitals or NHS facilities, an unresolved issue remains where the bulk of the tests should be carried out – with a network of "up to 50 regional testing sites by the end of April."

On April 17 Hancock told the Commons health and social care committee that testing was "available to everybody who needs it across the NHS," and that the 22 drive through testing centres in operation had been "big policy successes." This success does not seem to have been reflected on the total of just 50,000 people who had been tested for coronavirus.

Nor is it clear that all test centres are open to all of the categories of workers listed by the DHSC: some turn out to be only for over 18s.

Care staff face longer journeys

On April 19 the Telegraph complained care staff from Norfolk were being required to travel to Sheffield for tests, despite the establishment of a centre in Norwich Research Park for NHS staff. There have also been complaints of care staff having to drive from Dorset to Gatwick airport for testing – a near 300-mile round trip, while plans are discussed for a potential testing site in Bournemouth or Poole.

BMA GP committee chair Dr Richard Vautrey has warned there are challenges in some parts of the country with access to the 27 testing facilities, as GPs

continued page 4

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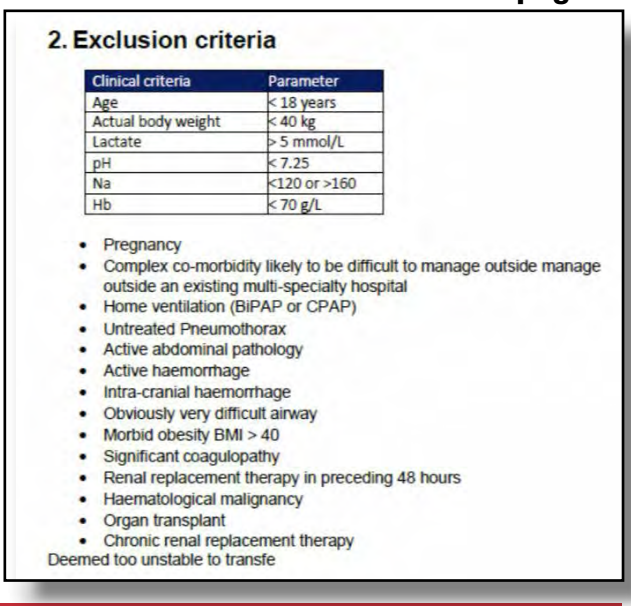

2. Exclusion criteria

Clinical criteria	Parameter
Age	< 18 years
Actual body weight	< 40 kg
Lactate	> 5 mmol/L
pH	< 7.25
Na	<120 or >160
Hb	< 70 g/L

- Pregnancy
- Complex co-morbidity likely to be difficult to manage outside manage outside an existing multi-specialty hospital
- Home ventilation (BiPAP or CPAP)
- Untreated Pneumothorax
- Active abdominal pathology
- Active haemorrhage
- Intra-cranial haemorrhage
- Obviously very difficult airway
- Morbid obesity BMI > 40
- Significant coagulopathy
- Renal replacement therapy in preceding 48 hours
- Haematological malignancy
- Organ transplant
- Chronic renal replacement therapy

Deemed too unstable to transfe

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Testing fiasco continued from page 3

complained that the location of test sites required journeys of an hour or more to be swabbed.

The BMA called for facilities to be set up in every CCG – four times the proposed number.

Recent announcements include a testing centre in Ebbsfleet to serve the large Kent area, where testing is currently confined to NHS hospitals testing only NHS staff. But the new centre is to be run not by the NHS, but contracted out to G4S – not a name that will inspire much confidence in care staff or other key workers. Testing at another new centre at an Oxford Park & Ride will be run by Boots and Serco.

The Guardian reports that the contracts for private companies to run the testing sites has been carried through without any competition, under the provisions of the 2015 Public Contract Regulations.

It looks like easy money for the contractors, since the workload is low, with little obvious accountability or regulation.

Farce

The Daily Mail has denounced "Britain's coronavirus testing farce", with pictures of deserted stadium and theme park car parks, fuming: "drive-through centres are only swabbing a handful of people every day - with a week to go to meet the Government's pledge of swabbing 100,000 people a day." The Sun argues that "Matt Hancock needs to stop pretending his coronavirus testing strategy is anything but a fiasco".

As numbers of tests are cranked up towards Hancock's target there are reports of long delays at test sites and poor practice by private contractors.

Channel 4 News has also picked up on the exchange in the Commons between Labour leader Keir Starmer and acting PM Dominic Raab, in which Raab boasted of having increased testing capacity to 40,000 per day. Channel 4's Patrick Worrall comments:

"Let's be clear: the target Matt Hancock set out was not to increase capacity to 100,000 tests a day, it was to actually do those tests. The target was set out in writing at the time and is still available on the UK government website."

Now Hancock has announced a U-turn to re-establish tracking and tracing, and said that key workers can make their own appointments for testing via the government's website rather than go through their employers. However the forms are complex and for much of the morning after this announcement the website was not working.

Even if the booking system works, without accessible testing sites, it seems that 100,000 target for tests each day is unattainable. How will ministers spin their way out of that?

Covid-19 bonuses for prison staff

John Lister

While Matt Hancock continues to insist that now is "not the time" to discuss any increase in NHS pay, the Prison Service and the National Probation Service have agreed to fork out substantial bonuses in addition to overtime payment to staff willing to commit in advance to working an extra 9 hours per week for 4 or 12 weeks.

A March 23 document outlining "exceptional Covid-19 Special payment Schemes," leaked to The Lowdown, makes clear that the deal has the approval of the Treasury, and will be implemented "with immediate effect".

£500 extra for 4 weeks overtime

It offers an extra £500 for operational prison staff on top of overtime pay for those who sign up for 4 weeks, giving a total additional payment of £1,292: for those willing to commit to 12 weeks of overtime averaging 9 hours a week (to be worked over 14 weeks) the bonus is £1750 and the total additional payment would be £4,126.

Similar bonus payments on top of overtime pay are open to non-operational prison staff, with a £1,500 per month bonus payable to Operational Managers who work additional hours: and there is also "exceptional bonus payments" of £20 per shift for "Escorts and Bedwatch" staff dealing with prisoners suspected to be infected with Covid-19.

For those willing to commit to 12 weeks of overtime averaging 9 hours a week (to be worked over 14 weeks) the bonus is £1750

The document also outlines similar payments for probation officers and management, and in addition agrees an additional £150 per month Covid-19 Special Circumstances payment to "any staff working in an offender facing role" or those who volunteer for additional duties "to support the operational line".

Prison officers are on pay scales similar to nursing staff, beginning on £22-£30,000. The trade unions that have negotiated the deal, NAPO for prison staff, along with UNISON and GMB for the probation service, have been pressing on other pay issues and on additional safety measures for staff during the Covid-19 pandemic: UNISON stresses that any agreement to work the extra overtime is purely voluntary.

Operational allowance

Meanwhile Liberal Democrat acting leader Ed Davey has suggested front line NHS staff proposal should be paid an additional £29 per day, as the equivalent to the daily operational allowance payable to UK military personnel when they are deployed on specific operations in "demanding" conflicts.

Hancock has rejected this. But NHS staff (who have been told any increase is out of the question, told to re-use single use PPE, threatened if they raise any public complaint at the lack of adequate safety measures, and fobbed off with a weekly round of applause), private contractors' staff working in support services – many of them with inferior sick pay and other terms and conditions compared with NHS staff – and social care staff, many scraping a living well below the living wage and offered only one of Matt Hancock's green badges instead of PPE, may well feel aggrieved.

If it's fair to reward the extra efforts and "bedwatch" duties of prison staff in these stressful and potentially dangerous times, why not NHS and social care staff too?

Questions raised over wisdom of "Nightingale" hospitals

John Lister

In the late 18th century Russian prince Grigori Potemkin is alleged in popular myth to have built impressive fake villages along the route to be travelled by Empress Catherine the Great, to give the illusion of prosperity.

In the early 21st century, NHS England seems to have taken a leaf out of Potemkin's book, by commandeering a vast exhibition and conference centre, and with logistical help from the army created the appearance of a huge "new hospital" more than four times the size of most normal general hospitals.

It has made some good headlines, and has actually been compared with the massive Chinese effort in Wuhan, which involved clearing land and building a vast prefabricated hospital from scratch in just ten days: but reconfiguring a large modern pre-existing building comprised mostly of open space is not really in the same league, and questions are now being asked about how wise it was to do this, and whether the building has proved to be an asset or a liability.

Missing ingredients

Not least because just as the villages were hollow facades, the hospital turns out to be lacking two key ingredients for success – staff, and patients.

Indeed while it appears that the hospital has been speedily equipped with 500 brand new beds and even hard-to-find ventilator machines, it has a desperate shortage of staff with the intensive care expertise to use the ventilators, and patients to use them on. Just one 42-bed ward is actually being used.

Admission criteria for the hospital leaked to the HSJ and shared on Twitter by the Independent's Shaun Lintern appear to exclude all of the most serious levels of illness that might require ventilator treatment ("any patient scoring above five on the clinical frailty scale"):

"The exclusion criteria say any patient with significant complications or serious intensive care needs such as renal replacement therapy, or filtering blood in place of the kidneys, are automatically not eligible to be taken there, leaving many of the sickest patients with London hospitals."

More recent accounts suggest it is designed more as a step-down facility for patients who have come through ICU rather than as a front-line treatment centre. As Lintern points out it is a "field hospital" and:

"The Nightingale, in line with many makeshift ICUs across the country, is also using anaesthetic ventilators with only a small number of normal intensive care ventilators."

The equivalents in Birmingham and Manchester are explicitly aimed at receiving less serious step-down patients, while as soon as it opened it was announced that the Yorkshire Nightingale, in Harrogate, would be kept empty while existing hospitals continue to cope.

And as stories revealing the minimal numbers of patients being treated at the giant ondon "Nightingale" hospital break into the mainstream media, it appears from reports to the Lowdown from worried staff in other trusts that NHS England bosses are stepping up the pressure on hospital chief executives across London and the south east to dispatch staff to boost the numbers on hand at the Nightingale, and also to send patients to use more than a couple of dozen of the boasted potential total of up to 4,000 beds.

Just as Potemkin villages were hollow facades, the hospital turns out to be lacking two key ingredients for success – staff, and patients

Pressure

A detailed Independent report underlines the problem: the hospital has too few patients to justify its existence, but also too few staff to take any more, and more could only come by piling more pressure on hospitals that are just about coping so far to cope with fewer staff. It quotes one member of staff at the Nightingale:

"Our goal is to relieve the pressure on London and if we had the staff, we would be more than happy to take more patients. The only rate-limiting step is staffing."

Of course on one level the fact that the huge additional number of beds have not been required, and NHS trusts in the capital and surrounding area have managed to cope with the Covid-19 crisis so far by cancelling almost all elective work, emptying beds of patients and revamping operating theatres as makeshift ICUs is a good thing. It also makes sense for the NHS to reserve some spare capacity to treat a potential second wave of covid-19 infections as the current lockdown begins to unwind.

But whether it was sensible to virtually close down all other treatment in hospitals, including cancer surgery is more questionable, especially in the context of a known and continuing staff shortage.

Such large new temporary units could only start up using staff taken from the busiest parts of functioning and highly-stressed hospitals.

It has led to record low occupancy levels (averaging 41% across England compared with a pre-covid average of over 90%, and down to 72% even in the hard-pressed London area)

Meanwhile the impact of the mass discharge on the social care sector has yet to be fully analysed: it's clear that deaths in care homes and at home, which are not included in the government's daily total of covid-19 deaths have continued to rise, and the Financial Times estimates could mean that the real total of covid-related deaths is well over 40,000.

Why bypass NHS labs for mass testing?

Concerns over new super-labs

John Lister

Staff in NHS laboratories are increasingly alarmed at the implications of the government's turn to create a new network of "super-labs" to process what is supposed to be a rising number of tests for Covid-19, leaving NHS labs under-used.

The development of a new network of labs running parallel to the NHS has taken place with no transparency and no attempt to consult with the unions.

NHS scientific staff in south London have now contacted the ***Lowdown*** to express their frustration that while they have the capacity to process large numbers of tests, the NHS labs are struggling to get supplies of the kits and the reagents required.

One member of staff explained their concerns: "I am so annoyed about this testing fiasco.

"I want to know why the new super-labs have been set up, because if they gave the NHS labs the resources they could easily to the tests. Our lab has been ready for ages to do large numbers of tests. We have the equipment and we have staff.

"We could do up to 5,000 tests every 24 hours if we really pushed, and people are quite willing to do extra nights for a while. But we can't get the bloody kits! Public Health England and NHS England and some other body are in charge of kit allocation and it seems they are saving them all for the super-labs."

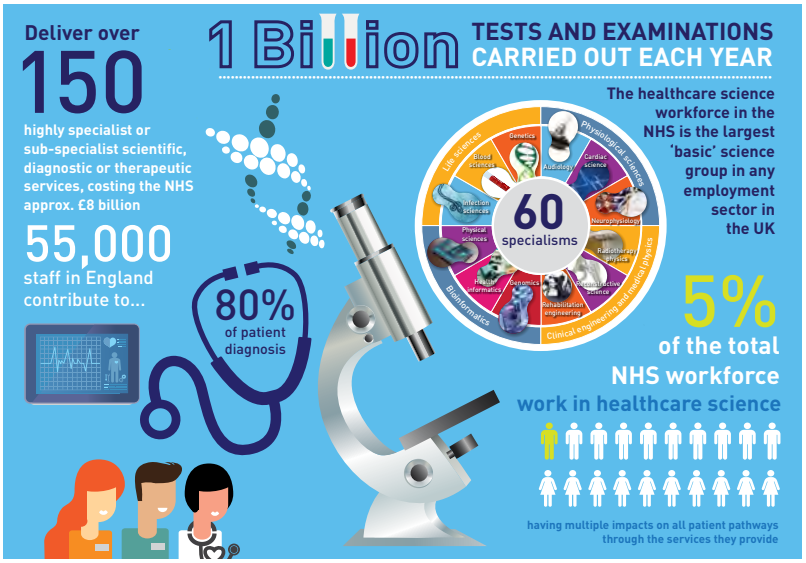
In early April a former director of the World Health Organisation, Professor Anthony Costello, argued the 44 labs in the UK were underused.

Qualifications

NHS staff are also concerned over the qualifications of the staff who are being recruited to these new 'Lighthouse Labs', who according to the architects of the plan include 'highly qualified staff and volunteers.'

"We don't know how the staff for these super-labs are trained, or if they are accredited. Nobody seems to know who is running them, and it doesn't seem to be under the jurisdiction of our professional body," says our South London contact, who correctly fears extensive private sector involvement.

The Glasgow lab -- in a university building



The leading biomedical science professional body has spoken out about the new super-labs

In fact the new labs have been created through a partnership with the Department of Health and Social Care, Medicines Discovery Catapult, UK Biocentre and the University of Glasgow, supported by both NHS and Public Health England.

The Alderley Park site is "working closely with AstraZeneca," and the Glasgow facility is linked with "BioAscent Discovery Ltd"; another drug giant GSK is also involved.

The new labs have extensively borrowed testing equipment from "dozens of universities, research institutes and companies across Britain."

Professional body speaks out

However it's not just NHS lab staff who are alarmed at this new development: the President of the Institute of Biomedical Sciences (IBMS), the leading professional body for scientists, support staff and students in the field of biomedical science, has also spoken out expressing concerns about the establishment of the new super-labs:

"It concerns me when I see significant investments being made in mass testing centres that are planning to conduct 75,000 of the 100,000 tests a day.

"These facilities would be a welcome resource and take pressure off the NHS if the issue around testing was one of capacity. However, we are clear that it is a global supply shortage holding biomedical scientists back, not a lack of capacity. ….

"The profession is now rightly concerned that introducing these mass testing centres may only serve to increase competition for what are already scarce supplies and that NHS testing numbers will fall if their laboratories are competing with the testing centres for COVID-19 testing kits and reagents in a 'Wild West testing' scenario.

"The UK must avoid this for the sake of patient safety."

The IBMS statement also raises the issue of the quality of the work to be done by the new labs and the failure to involve the professional body:

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The Milton Keynes mega-lab has been located in an existing large NIHR building

"It is clear that two testing streams now exist: one delivered by highly qualified and experienced Health and Care Professions Council (HCPC) registered biomedical scientists working in heavily regulated United Kingdom Accreditation Services (UKAS) accredited laboratories, the other delivered mainly by volunteer unregistered staff in unaccredited laboratories that have been established within a few weeks.

"This has presented another key concern – in that we have not been involved in assuring the quality of the testing centres and are now being kept at arm's length from their processes, even when they exist close to large NHS laboratories."

The IBMS statement calls for merging the existing NHS labs with the new testing centres into "one stream".

Unite's National Officer for health Colenzo Jarrett-Thorpe echoes these concerns:

"We are concerned that the considerable skills of the NHS scientific workforce has not been fully utilised during the pandemic emergency.

"Reports of private pathology providers to NHS furloughing their staff, albeit on a voluntary basis, does not give confidence that the correct decision are being made.

"In addition, we have been given little information about the staffing and quality assurance arrangements of the super testing laboratories and it is unclear who is responsible for their operation and implementation amongst the spaghetti junction organisation of the English health system. "Unite will be seeking answers and positive engagement on these issues."

However the government has pressed ahead regardless, opening three new super-labs in Milton Keynes, Glasgow and Alderley Park in Cheshire, boasting that "each individual site took just 3 weeks to complete and begin testing," and quoting the newly-appointed National Testing Coordinator Professor John Newton describing the super-labs as "the biggest network of diagnostic labs in British history."

Meanwhile in an apparently unconnected move an additional, fully private sector "super-lab" with capacity to process up to 30,000 tests per day is being built in Cambridge by AstraZeneca and GSK.

It is clear that two testing streams now exist: one delivered by highly qualified and experienced, registered biomedical scientists in heavily regulated accredited laboratories, the other delivered mainly by volunteer unregistered staff in unaccredited laboratories.

Revamping premises

Each of the "new" Lighthouse sites has taken over premises from a previous facility: the Milton Keynes super-lab is converted from a biosample centre set up in 2015 by the National Institute for Health Research at a cost of £24m. The Alderley Park site was previously owned by AstraZeneca site, sold to Manchester Science Parks in 2014, while the Glasgow lab is hosted by the University of Glasgow in repurposed university laboratories at its Queen Elizabeth University Hospital campus.

According to a BBC report all kinds of people have a finger in the pie of the Glasgow lab, which is "a collaboration between the University of Glasgow, the private sector, the Cancer Research UK Beatson Institute and the NHS, and is mostly staffed by volunteers. The lab has also been set up with help from the armed services and has logistics help from accountancy firm Deloitte."

The BBC interview with Glasgow head scientist Dr Stuart McElroy makes clear both the limited initial capacity of the new lab, which he claims can process "many hundreds" tests a day: but also the lack of any connection between the super-labs and the existing NHS laboratories across the UK:

"Dr McElroy says being part of the network of superlabs allows the teams to create standard processes and quality control as well as learning from each other. They can also distribute samples efficiently across the three sites."

It seems that disjointed government thinking has wound up developing a complex and unaccountable parallel structure of labs, rather than ensuring the existing labs get the supplies they need to do the job.

When the Covid-19 crisis eventually unwinds, and the various temporary arrangements are ended, with the universities wanting their equipment back, NHS lab staff will have a fresh fight on their hands to ensure their services are not starved of resources or further privatised.

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NHS sees revolution in digital GP healthcare

Sylvia Davidson

The coronavirus pandemic has accelerated the use of digital health solutions in the NHS. On 5 March, NHS England sent all GP practices a letter advising that patients be assessed online or via telephone and video appointments to mitigate the potential spread of coronavirus.

Although aimed at around 7,000 GP surgeries, hospital departments also needed to very rapidly reduce face-to-face appointments and change the way they worked.

What happened next has been the most dramatic change in the way the NHS works since its inception. Now almost two months later, thousands of GP surgeries and hospital departments are using video or telephone appointments and millions of patients contact healthcare providers remotely. Digital health solutions are now embedded in the way the NHS works.

NHS Digital reported that in March, the use of the NHS App increased 111%, with repeat prescriptions made via the app up 97% and the number of patient record views up 62%.

16 million more users

Prior to the coronavirus outbreak the service recorded an average of 10,000 users per day, but in March more than 16 million people used the service, and pharmacies saw an increase in electronic prescription services of more than 1.25 million.

Livi, which already has a foothold in the market as a provider of remote consultations to the NHS through its app, recorded a 107% increase in consultations from 1 February to 13 March compared with the six weeks before.

The change has also been a boon to several companies. These companies, already spurred on to develop digital solutions by Matt Hancock's spaniel-like enthusiasm for apps and the long-term plan published in January 2019, are now becoming embedded within the NHS, probably a couple of years before any of them ever expected to be.

On the 19 March, NHS England issued a 48-hour tender for the immediate provision of online primary care consultation. The accelerated tender documents were issued to a group of 33 trusted NHS suppliers by NHS England National Commercial Procurement Hub. Successful companies were told on 25 March.

There were five lots available, including text messaging, video consultations and automated triage. Eleven suppliers have been selected to provide video consultations for primary care.

Each supplier has been told they will be working with a number Clinical Commissioning Groups (CCGs) but the exact regions are yet to be confirmed. The companies are: LIVI; Doctorlink; eConsult; EMIS; Engage Consult; iPLATO; Q Doctor; Lincus; Ask NHS; FootFall; and Visiba Care.

Some of the technology to be supplied is Covid-19 specific, including Engage Health Systems and eConsult's technology to provide a template which will signpost patients with suspected Covid-19 to appropriate services after they've answered a series of yes/no questions.

Other technology is applicable across the NHS, such as video consultations and text messaging technology.

Digital Health News reported that it's not known whether the big names like Babylon bid on the tender, but the company is absent from the supplier list.

Outside of the NHS England tender, providers of digital solutions to GPs had already responded to produce new products and many were already reporting an increase in uptake.

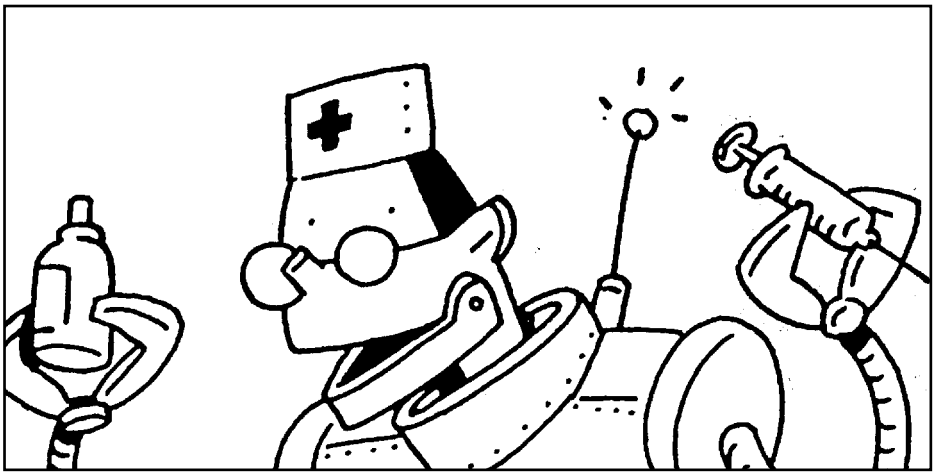
The change has also been a boon to several companies which are now becoming embedded within the NHS before any of them ever expected to be.

Video-calling

After the letter from NHS England, many GPs turned to the company accuRx. The company's technology was already being used by many doctors for sending text messages to patients, but accuRx rapidly built a video-calling system and it now provides the video system and a screening survey for free to GP surgeries.

Nye Health, a company specialising in primary health, reported that it has had rapid uptake of its new platform that allows all GPs in the NHS to carry out appointments remotely, designed specifically to respond to the current pandemic. The company already works with many GP surgeries in Oxford, but is now seeing enquiries coming thick and fast from other areas.

Babylon Health, perhaps the best known of the digital health companies, has devised its own Covid-19 app, the COVID-19 Care Assistant, and made it available to its NHS and private patients. On 8 April the Royal Wolverhampton NHS Trust (RWT) and University Hospitals Birmingham NHS Trust (UHB) began using the new service to support and monitor coronavirus patients 24/7 in the community. All together Babylon Health notes that the app is now available to 4.2 million patients.



10-year 'digital first' deal

Earlier this year the Royal Wolverhampton Trust signed a 10-year deal with Babylon earlier this year to develop a "digital-first integrated care" model.

Other companies have accelerated the launch of products. DrDoctor has launched a

free Covid-19 toolkit for NHS trusts, which includes the company's broadcast messaging and video consultation services along with a digital symptom assessment tracker. The toolkit was due for launch at the end of 2020.

The tools enable consultants to carry out remote consultation capabilities in hospitals and communicate any service changes to patients. DrDoctor's Symptom Tracker can send digital assessments to patients to screen for coronavirus symptoms before hospital appointments or on an ad-hoc basis.

In the Midlands, Walsall Healthcare NHS Trust has implemented online consultation software from Healthcare Communications. The E-clinic software allows patients to see their clinicians via online consultations, from their own homes, meaning that regular health checks and medical reporting can continue even if patients or healthcare professionals are self-isolating. The trust has 40 clinicians set up to use the system.

Quick change

A major component of the long-term plan published in January 2019, was the digitisation of the NHS. But nobody could have foreseen how quickly this would take place.

How successful it has been is an unanswered question, however. The figures show that people are using the systems, but there is no way of knowing yet how many people are being left behind and unheard due to a lack of tech knowledge or the hardware to access digital health. There is also no way of knowing how many people will stick with the remote consultations when they are not obligatory.

What is certainly true is that after the pandemic, the NHS will not go back to the way it was working. Things have changed, the NHS is now a long way down the road to digitisation. In some respects this is a positive for the NHS, it has exhibited the ability to rapidly change and innovate, something that many critics wouldn't have thought possible even a few months ago. In the area of IT, the NHS has a history of disasters and was a laughing stock for its continued use of fax machines.

The NHS has exhibited the ability to rapidly change and innovate, something many critics wouldn't have thought possible even a few months ago

The spread of the technology among NHS primary care and hospital trusts has also put the NHS in an excellent position to compete with digital health companies, such as Babylon Health.

Competition

Babylon has sought to compete with the NHS' system of primary care more than any other digital health company.

Its model is one of remote working, using its own GPs, with a limited physical infrastructure. Patients who signed up to Babylon, although still treated by the NHS, had to leave their GP surgeries and re-register with Babylon.

Now, however GP surgeries and hospital departments will be able to offer a range of appointment solutions, all without having to register with a different GP. They can offer all the advantages that companies like Babylon boast of, but without the downside of not having a physical surgery for attending when you really need to.

Trials and tribulations: the race for Covid cures

Martin Shelley

As the push to find a cure for Covid-19 intensifies, here's our take on the latest developments…

The search for a drug that's safe enough to treat existing Covid-19 patients could take months, if not longer, despite the best efforts of Big Pharma to repurpose products originally specified for use against diseases like malaria and ebola.

And finding an effective vaccine – immunisation now being widely accepted as the only real exit strategy from socially repressive lockdowns – could be more than a year away, even though rival companies and consortia are racing to shorten development timelines and deliver sooner.

These delays have inevitably led to hastily devised, albeit useful, stopgap measures – lockdowns, social distancing and testing. But they've also opened up a window of opportunity for a ragbag of rogues, from online fraudsters with an eye for a quick buck – vitamin C-based 'immune boosting' IV drips at £350 a pop, anyone? – to conspiracy theorists peddling the use of liquid silver and sliced onions, all the way up to democratically elected politicians endorsing unproven crackpot fixes.

Disinfectant

Take US president Donald Trump, for example, whose latest suggestions – injecting disinfectant and bathing in UV light to hasten recovery from Covid-19 – have rightly engendered confusion and hilarity among experts and commentators alike. "I can't believe that in 2020 I have to caution anyone listening to the president that injecting disinfectant could kill you," said one in despair.

In India, members of the ruling BJP party have touted the idea of drinking cow urine as a cure for Covid-19, while over in Brazil a congressman has claimed a day of fasting would easily do the trick.

Next door in South America, Venezuelan president Nicolas Maduro mooted the notion that lemongrass and elderberry tea could ward off the virus, an idea taken up more recently in Africa, where Madagascar's president Andry Rajoelina has launched a herbal tea 'cure' for those considered most vulnerable.

Taking a more responsible approach, thankfully, is France, where the government is warning citizens to be wary of taking cocaine or spraying the body with chlorine, bleach or alcohol in order to reduce the chance of catching Covid-19 – all myths recently promoted on social media.

Nicotine patches

The idea that nicotine patches can protect smokers from catching the virus is, however, being taken more seriously in the land of Gitanes, as it's now the subject of clinical trials following research undertaken at a Paris hospital.

But let's go back to Mr Trump and consider his (now former) 'go to' treatment of choice, hydroxychloroquine and its close relative chloroquine. He's been relentlessly hyping up these pharmaceutical cocktails, originally developed to target malaria, for most of this year, and has taken to verbally abusing any journalist brave enough to question him on the topic at his regular media briefings.

Perhaps we'll never know the real reasons for Trump's enthusiasm – he even falsely claimed that these drugs had been approved by the Food & Drug Administration to treat Covid-19 – but we note that the New York Times wrote earlier this month that he holds a "small personal financial interest" in Sanofi, a company that makes a branded version of the drug called Plaquenil.

Quite what effect that enthusiasm had on his electorate we can't say, but last month in Arizona a man died after taking chloroquine phosphate, an additive used to clean fish tanks but also found in the anti-malaria medication.

The president and his conservative supporters at Fox News have since backed away from promoting hydroxychloroquine after a large trial at US military hospitals showed that it offered no benefits to the veterans who were the trial's subjects. A third of those patients died when treated with the drug, more than the number who had received standard treatments.

Similarly poor outcomes emerged during a more recent Brazilian study, which had to be halted after a high dose of hydroxychloroquine proved lethal for some patients.

But while Trump may have now seen the error of his ways, other drug trials are continuing to examine the possible efficacy of hydroxychloroquine, if only, perhaps, to rule it out. Its seeming ubiquity has also been boosted by reports that, in the absence of a proven remedy, hospitals in several US states have started giving the drug to patients.

Take as an example the Recovery trial, said to be the largest trial in the world, which has just been set up in the UK, with more than 5,000 patients in 165 NHS hospitals. Despite a paucity of supporting data for the anti-malaria drug, the professor co-leading the trial admits hydroxychloroquine will nevertheless be tested.

The idea that nicotine patches can protect smokers from catching the virus is, being taken more seriously in the land of Gitanes, following research undertaken at a Paris hospital

WHO clinical trial

Hydroxychloroquine was also selected by the World Health Organisation (WHO) as one of four products chosen for its international clinical trial. And in another recent trial, not peer-reviewed, and this time in China, claims were made that patients with mild Covid-19 symptoms who were given hydroxychloroquine recovered faster than those who didn't, and none went on to display more serious symptoms.

However, last month a team of French researchers were unable to duplicate the positive results of an earlier and much disputed study – examining the effectiveness of hydroxychloroquine when used in combination with an antibiotic called azithromycin – by a group of scientists in Marseille, which had led to misleading claims of a "100% cure rate" being made on Fox News in the US. A panel set up by the US National Institute of Allergy and Infectious Diseases (NIAID) later advised against the combination of these two drugs, however, because of the associated risk of cardiac arrhythmia.

And last week the pharmaceutical giant Novartis, parent company of Plaquenil manufacturer Sanofi,

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announced it was going to conduct a trial "within the next few weeks" of hydroxychloroquine as a treatment for patients hospitalised with Covid-19 at more than 12 sites in the US.

Despite all the hype, let's not forget that hydroxychloroquine is just one of more than 100 potential treatments for Covid-19 that are in various stages of being tested. More innovative drugs are also on trial, focusing on antibodies taken from patients who have recovered from the virus, and also on thwarting the human body's sometimes dangerously hyperactive immune response to Covid-19.

Swiss pharmaceutical giant Roche is evaluating its rheumatoid arthritis drug tocilizumab to see if it can interrupt and control that immune response, while biotech start-up AbCellera – in collaboration with Indiana drugs firm Eli Lilly – and New York company Regeneron are both rushing ahead testing products using antibodies, but the results of these trials could still take months, with no guarantee of success.

Ebola

But it was another drug, remdesivir, that until recently appeared to hold out the best hope of success. Made by US company Gilead Sciences, and first developed – with a little help from the US government to the tune of nearly $80m – for use during the 2013-16 ebola outbreak in west Africa, remdesivir was considered to have potential because Covid-19 shares important features with that earlier virus.

Like hydroxychloroquine, it has been given to Covid-19 patients on compassionate grounds ahead of any trial results, and its popularity has led to supply shortages serious enough to preclude its presence in the Recovery trial. Earlier this year Gilead released purely anecdotal data from this compassionate use, instead of waiting for the outcome of formal clinical trials, which led Trump to talk it up at his next media briefing.

Anticipation of its success is said by some US commentators to be behind the decision of the Trump administration to award the product 'orphan' status, thus entitling Gilead to profit from remdesivir exclusively for seven years, ruling out the possibility of cheaper generic versions becoming available which could be distributed more widely. It has been noted in the US that a member of Donald Trump's 'coronavirus task force' previously worked for Gilead.

However, following widespread criticism of the move – senator Bernie Sanders branded the decision "outrageous" – Gilead asked the Federal Drug Administration to rescind the designation.

Back in February, WHO's assistant director-general said, "There's only one drug right now that we think may have real efficacy. And that's remdesivir." Initial results from researchers at Chicago University were encouraging, but documentation that briefly appeared on the WHO clinical trials database this month revealed that remdesivir did not work in its first full trial in China, and that the trial had to be stopped early because of side-effects.

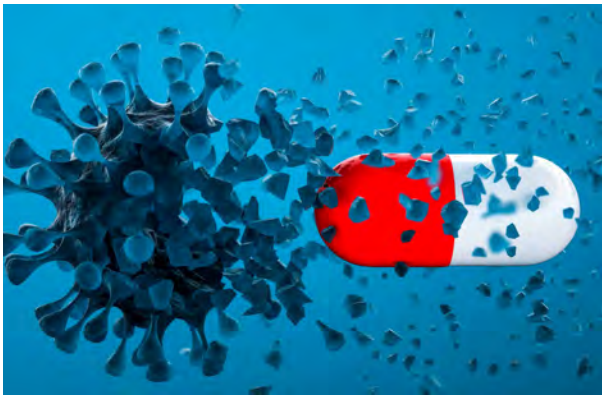
False starts will no doubt feature in the parallel race to develop a vaccine to immunise against the virus. There are reported to be more than 100 development projects on the go across the globe

Similar false starts will no doubt feature in the parallel race to develop a vaccine to immunise against the virus. There are reported to be more than 100 development projects on the go across the globe – looking at every possibility, including repurposing products currently used to treat tuberculosis and polio – with nearly 80 said to be on the WHO's radar, and among the more high-profile participants already conducting trials, or with regulatory approval to start them, are Pfizer (in collaboration with Germany biotech company BioNTech), Sanofi (working with GSK) and Johnson & Johnson.

Human trials

In the UK, researchers from Oxford University have just begun human trials as part of the Oxford Vaccine Group project, having recruited more than 1,000 volunteers across study sites in Bristol, London and Southampton, in addition to Oxford.

But even if one or more of these trials proves successful, taking a vaccine all the way through to regulatory approval and widespread distribution takes time – historically up to a decade or more. Hopefully the timetable during the current pandemic will be much shorter, but – despite Trump's plea for a vaccine to be ready in time for the US presidential election in November – senior medical experts such as Anthony Fauci, director of the US NIAID, have cautioned that a vaccine won't be available for at least another 12-18 months, which is the shortest timeline to complete clinical studies.



So it looks like we'll be living with face masks, lockdowns and social distancing for some time yet. The mobile phone apps slowly coming on stream, designed to boost the effectiveness of the contact tracing measures that should have been in place for the past few months in the UK, will no doubt help, but it's going to be a long, slow process before we see light at the end of the tunnel…

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Trump and the UK Trade Bill, why should we be worried?

Sylvia Davidson / Paul Evans

The new Trade Bill gives Parliament little say over future trade deals according to MPs and campaigners, but the government says it's just a technical bill.

The Trade Bill does not exclude the NHS and other public service from future trade negotiations.

The views of Wales, N Ireland and Scotland about future trade deals could be sidelined.

Since the election the government has reverted to a stripped back version of the Trade Bill dropping previous checks and balances.

Why is the Trade Bill needed?

Now we are no longer part of the EU, the Government's Trade Bill is needed to enable ministers to implement existing trade deals. Originally negotiated by the EU these deals will be rolled over, at the end of the transition period.

The bill also enables the UK to run its own trade policy and the government highlights the need to defend UK industry from issues like the dumping of cheap goods; and the bill establishes a new quango, the Trade Remedies Authority to take on this work.

What the Trade Bill will allow the government to do?

The Trade Bill will allow the Government to extend existing trade deals, negotiate changes to any existing deals and set up new deals. However, the Bill has ditched the amendments that were made to it before the election, responding to criticisms that the Bill offered no process for Parliament to properly scrutinise or object to future trade deals.

The government claims that its Trade Bill is only concerned with the EU trade deals that have already been ratified, saying that 'translating' these deals into UK deals post-Brexit is just a technical exercise. Therefore, Parliament's role is unimportant in this process as scrutiny has already taken place, both at EU level and via the EU Scrutiny Committee.

However, this is not totally true as the Trade Bill also covers negotiations and trade deals with countries seeking to alter the previous EU deal and those seeking to negotiate new deals.

A case in point, negotiations between the USA and UK over a post-Brexit deal have already begun and negotiations for this deal would be covered by the Trade Bill.

Why are campaigners concerned about the Trade Bill?

The main points that concern campaigners are 1) the lack of provision for Parliament to scrutinise and reject any trade deals, 2) the inclusion of some sweeping powers to change primary legislation, and 3) the fact that the NHS is not excluded from trade deals. There are also issues with how it impinges on the devolved nations - Sotland, Wales and Northern Ireland.

Negotiations between the USA and UK over a post-Brexit deal have already begun and negotiations for this deal would be covered by the Trade Bill.

Scrutiny and a vote

The scrutiny of trade deals while we were members of the EU, was delegated to European Institutions and the UK EU Scrutiny Committee. Critics believe a new Trade Bill should include provisions for adequate scrutiny of negotiations and trade deals by Parliament.

UK rules for negotiating on trade do exist, but are decades old and are regarded as unfit for the contemporary challenges of reaching new deals with the USA or China.

David Lawrence a senior political advisor at the Trade Justice Movement, a network of 60 civil society organisations campaigning for trade rules, believes that currently:

"Our elected representatives will struggle to stop a bad US trade deal, even if it were roundly unpopular and known to be harmful"

Under the proposals, there is no requirement to consult the public and virtually no role for Parliament until after the deal is signed. At the very end of the process, Parliament is asked to ratify the deal in a procedure dating from the 1920s which is outlined in the Constitutional Reform and Governance Act 2010.

The use of this Act can be tricky as it relies on sufficient time being allotted to the opposition for discussion of the deal.

Under the rules, Whitehall (the Government) is able to decide when and who to start negotiations with, decide its own priorities and objectives, conduct negotiations, usually in great secrecy, and conclude and sign the eventual deal.

The Institute for Government concludes:

"The current arrangements give Parliament a limited role. It can vote to delay the ratification of trade deals, or could prevent them being implemented by voting against changes to tariff rates or regulation.

"However, given the potential economic and policy implications of future trade deals, government should guarantee Parliament a direct vote on any future deals before they are ratified."

Talks between the USA and UK, already underway, are not subject to scrutiny and the Trade Bill in its current form will mean that they continue to be conducted in secret with little Parliamentary or public involvement.

Campaigners want the Trade Bill to be amended to make it a requirement to update Parliament on what is going on and to conduct negotiations openly and transparently. To be meaningful scrutiny must include, they say a Parliamentary vote to approve any new trade deals.

Sweeping powers

The Trade Bill also provides the Government with the authority to amend primary law for the implementation of an international trade agreement.

These changes could have a major impact on fundamental rights and consumer protections across a number of areas of society. For example, if the international trade deal asked for the lowering of food or farming standards.

Inclusion of the NHS

The Trade Bill does not specifically exclude any area of public services, including the NHS from negotiations, such as those with the USA.

The NHS could be left out if trade negotiators agreed to use an approach known as positive listing for services which means that only the named services would be included in a trade deal and everything else is off the table.

Of course, the government claims there is no need for such a provision as "The NHS is not, and never will be, for sale to the private sector, whether overseas or domestic."

However despite this denial, in November 2019 leaked trade papers from the US/UK negotiations showed that the US is demanding a negative listing system which works the opposite way - all services are on the table unless specifically exempted. Protection for public services is a lot harder to work this way, as every single service has to be listed in detail and then exempted.

The organisation Global Justice Now points to a more secure way to exclude the NHS through a broad watertight carveout for public services, based on the definition by the European Public Services Union, effectively excluding the NHS (and other public services) from the trade deal.

NHS campaigners see significant threats if the NHS stays on the table. It is not widely recognised that US firms already have access to NHS contracts through the current tendering system, but US firms would seek other market advantages, like the strengthening of intellectual property rights for companies who hold patents and data about the drugs they market, which could delay patient access to cheaper generic drugs.

They would likely push for access to the British NHS's unique database of 55 million patient records, which have been estimated to be worth £5 billion per year to private companies.

Consultancy.uk has highlighted a recent paper from professional services giant EY which claims that the NHS could tap into a vital source of funding by opening up its patient records to private entities.

"We call on the government to pause all trade negotiations until the Covid-19 crisis is under control"

The bills impinge on the powers of the devolved administrations

These are all UK bills – but they all impinge on the powers of the devolved administrations.

The UK government enacted the Withdrawal Agreement Bill (WAB) despite all the devolved legislatures refusing legislative consent – the first time that has ever happened. Campaigners and MPs in these nations are almost certainly going to oppose this bill as well.

What stage has the bill got to in Parliament?

The Government published the Trade Bill just a few days before Parliament rose early to allow MPs to leave Parliament and self-isolate in their constituencies. The Bill was given its first reading on 19 March and as with all Bills at this stage it was passed.

The Bill is now awaiting its second reading, with a date yet to be announced. However, with the return of Parliament as a virtual entity on 21 April, this bill is likely to begin its second reading very soon.

This is the second time out for the Trade Bill - the original trade bill was put to Parliament in 2017. It reached a third reading in the House of Lords on 20 March 2019. The Bill faced many amendments and the session ended before it received approval.

What are campaigners doing?

The main focus of campaigners is the negotiations between the USA and UK. The Government announced in mid-March 2020 that it is committed to restarting negotiations as soon as possible.

These will be conducted in secrecy and will not be subject to any scrutiny if the Trade Bill in its current form is passed by Parliament.

On 23 March 2020, 17 organisations signed a letter to the Prime Minister and Secretary of State for International Trade, urging the government to delay negotiations and calling for proper Parliamentary and public scrutiny.

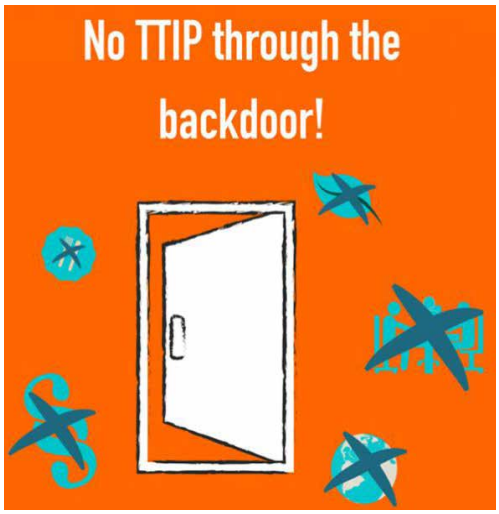
"These are high risk issues that need considered public debate and democratic scrutiny, but this debate cannot happen amidst national lockdown and with Parliament closed.

"Outside of a time of crisis, when the government has the time and resources to dedicate to negotiations, we expect full public and Parliamentary engagement with appropriate scrutiny and transparency throughout the process.

"We call on the government to pause all trade negotiations until the Covid-19 crisis is under control and to inform both the public and potential trade partners of this necessary action."

Glenrothes SNP MP Peter Grant has tabled a private members bill - The Trade Agreements (Exclusion of National Health Services) Bill - that seeks to exclude the NHS from trade deals and say that explicit consent of the Scottish, Welsh and Northern Irish Parliaments and Assemblies is required on any trade deals.

This is heading for its second reading in Parliament in July 2020.



After Covid-19: no return to failed laws and privatisation

John Lister

Boris Johnson's five minute broadcast on leaving hospital, in which he enthused about the NHS as the "beating heart of this country" and named two overseas nurses who he believed had saved his life might prove to have been a pivotal moment.

It might yet turn out to be the moment where he and his right wing cabinet were persuaded to pull back from the process of running down the NHS, slamming the door shut on migrant workers who throughout the life of the NHS have been key to its survival, and opening opportunities for private companies and private hospitals to carve out slices of the NHS budget.

Of course this has not ended the pressure from the neoliberal right wing of the Tory party and far right, who are yearning for an end of the crisis to further "reform" the NHS by intensifying competition at a time when collaboration has been proven to be key to the crisis response.

But their chances of success are limited by the reinforcement of the NHS during the epidemic as by far the most popular as well as the most universal public service, with even Dominic Raab suddenly singing its praises.

Wake up call

The entire coronavirus pandemic and resultant crisis facing every major country in the world has been a wake-up call for ministers, and they have already been pushed into decisions we could not have expected a few months ago.

The financial constraints that have effectively frozen NHS funding in real terms in 10 years of austerity have been lifted to fight the virus, Priti Patel's vicious Immigration Bill has been shelved, and health ministers and NHS England have been forced to put their plans for restructuring of the NHS on the back burner – or conceivably discard previous ambitions altogether.

The operation of the widely-despised 2012 Health and Social Care Act has been effectively suspended. Matt Hancock has been ignoring the Act, speaking and acting as if he is in fact responsible for the NHS; NHS England has taken over control at local level from Clinical Commissioning Groups; and the complex system of "payment by results" and contracting that were part of Andrew Lansley's plan for a competitive market in health care have also been halted during the crisis and replaced by an old-style system of block contracts.

One HSJ analyst has argued how much better the NHS could have coordinated its work if the 2012 Act had not axed Strategic Health Authorities, and even Newsnight reporters have recognised that the 2012 Act has proved itself to be an obstacle to proper planning and coordination of services.

NHS trusts' financial savings targets have been paused as well, to allow management to focus on their primary role of delivering health care. One top NHS hospital boss told the Health Service Journal: "It's completely unrealistic to think about how we can make workforce reductions and workforce savings [given the expected coronavirus demand]. … We have to be 100 per cent focussed on clinical need."

£13.4 billion of loans run up in recent years by trusts struggling to contain their deficits have also been written off – although it turns out this has been done (and could have been done at any time) without costing the Treasury any money.

At the beginning of the year new NHS England guidance had called for an end to any further acute bed closures, and for bed numbers to be maintained at the higher level of winter 2019-20

Long Term Plan, short term pause

NHS England has paused implementation of its controversial Long Term Plan, and urged local health bosses to do the same: already at the beginning of the year new NHS England guidance had called for an end to any further acute bed closures, and for bed numbers to be maintained at the higher level of winter 2019-20 – meaning that various plans for cutbacks and "centralisation" of services will have to be rethought.

In other words a completely new regime is now operating in the NHS, which has expanded its capacity, reopening closed beds as well as setting up temporary "Nightingale" hospitals, while its place in public affections has been reinforced.

So the question that arises is now people have seen how much better and more sensibly the NHS runs without the impediments of the 2012 Act, and how much better it can cope with additional beds open, how many of these generally positive changes can now be reversed, to restore pre-Covid-19 "business as usual"?

So now the Act has effectively been suspended, who can make a sensible case for bringing it back into operation, rather than scrapping the already widely-ignored and unpopular legislation?

And how can ministers who have so repeatedly and on so many different platforms professed their affection and admiration of the NHS during the epidemic follow the ending of the lockdown with a new financial crackdown that would require colossal, draconian cuts in key services, or a trade deal that would result in further widespread privatisation – especially to grasping American corporations?

There are other dilemmas, too, for the Tories when the crisis period is finally passed.

The NHS has block-booked 8,000 beds in private hospitals (the vast majority of Britain's small-scale private hospital network) – to allow NHS trusts to continue with some of their more pressing elective surgery while switching their own capacity towards Covid-19 patients and increased intensive care units.

Unlike some other countries, the private hospitals have not been requisitioned, but commissioned at an estimated £300 per bed per day: this gives a lifeline to a small private sector that is heavily dependent on NHS-trained staff, and on income from elective

Priti Patel may have to pause her bill and scrap racist "health surcharge"

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care for NHS-funded patients – treatment which is suspended for at least three months and probably longer.

While the private sector hospital bosses expect to be able to "bounce back" after Covid-19, there should be a discussion about whether any of their hospitals should be taken over permanently by the NHS. Not all the private hospitals are large enough or near enough to NHS hospitals to be of value, but should those that are be nationalised and integrated into the public system that delivers care to all?

The wider role of the private sector must also come under the spotlight in any reassessment.

The highly-publicised 3,600-bed Nightingale Hospital created in London's Excel Centre opened in record time – but with cleaning, and other support services contracted out to private companies including ISS, the company that triggered strike action from angry GMB members at Lewisham who had not been paid their proper wages as the epidemic set in.

So while the rhetoric of NHS England in recent years has focused on "integration," and Tory ministers have insisted we must all pull together, the same NHS England has decided that the support staff at the Nightingale should NOT be part of the NHS team, but part of the profit-seeking private sector.

Inadequate PPE – and sickness benefits

Across the country cleaners, porters and other support staff face the hazards of working with Covid-19 patients, many with inadequate personal protective equipment. At least two porters have died. Yet many of these services are contracted out to cheapskate employers, offering terms and conditions inferior to in-house NHS staff – especially on sick pay, which can result in pressure on staff, including outsourced 111 call centre staff, to come in to work while sick, potentially spreading infection. .

Recent research, looking at NHS data for 130 hospital trusts from 2010 to 2014 found that an average of around 40% of hospital trusts had contracted out their cleaning services, suggesting these contracts alone were worth £500m per year. The Covid-19 crisis is reminding so many more people that "unskilled" and underpaid staff in all public services are doing vitally important work, so it is important to ensure that the end of the crisis marks the start of a fresh campaign to bring all of these outsourced services in-house.

Department of Health and Social Care figures show the amount spent by the NHS on private providers of clinical services rose each year from 2006, from just over £2 billion to almost £9 billion by 2016, and the private sector share of NHS spending increased from 2.8% to 7.7% over the same period. However this flat-lined in 2016/17, and declined to £8.7 billion (7.3%) in 2017/18.

Other analysis by David Rowland of the Centre for Health in the Public Interest argues that the real level of spending on private providers of clinical services is much higher, with around 18% of NHS spending going to private providers other than GPs and dentists. This means £13.5 billion was spent on private providers in 2013-14, rising to £18.4 billion in 2018-19, a 36% increase.

Where does this money go? The BMA in 2018 found that 44% of NHS private spending was on community health services, 25% on general and acute services and 11% on mental health – although some sectors of mental health are extensively contracted out to private hospitals.

Analysis by Laing & Buisson in 2018 estimated 30% of mental health hospital capacity is now in the private sector. Other reports reveal 44% of the £355m NHS spending on Child and Adolescent Mental Health care goes to private providers.

The private sector domination is most complete in the provision of "locked rehabilitation wards", in which a massive 97% of a £304m market in 2015 went to private companies.

NHS acute trusts have been driven to outsource elective care to private hospitals. IFS figures show up to a third of NHS elective knee replacements and 20% of hip replacements are carried out in private hospitals.

In Devon University Hospitals Plymouth Trust has an 18 month partnership deal that moves 75% of the trust's elective orthopaedic work to Care UK's neighbouring private hospital.

However it's worth remembering that the overall scale of the private sector is still very small: according to the Independent Healthcare Providers Network just 6% of NHS elective admissions are now going to private hospitals. This leaves the NHS to deal with the other 94% – as well as 100% of the emergencies, complex and chronic care.

Support staff at London's Nightingale hospital have NOT been made part of the NHS team, but left as part of the profit-seeking private sector

Not just for pandemics

In the post-pandemic rethink, it's important to shine the spotlight on the scale of spending on private providers, and make the case once again for these contracts to be terminated and brought back in-house, with staff re-integrated into the NHS team, on NHS pay grades, terms and conditions.

Will post-pandemic Boris Johnson and his right wing cabinet be open to this? You are urged not to hold your breath waiting – but to press opposition MPs and the unions to take up the issue. A properly integrated NHS must not be seen as only for pandemics – we need it all year round!

Please donate to help support our campaigning NHS research and journalism

THE lowdown

Please support campaigning journalism, to help secure the future of our NHS





Dear Reader
Thank you for your support, we really appreciate it at such a difficult time.

Before Covid 19 the NHS was already under huge pressure and, after it's all over there will be a backlog of patients, queues of people affected by the crisis, and a hugely tired workforce.

From that moment we will need a much more credible plan to fund, support and protect our brilliant NHS. Our goal is to help make this happen and we need your help.

We are researchers, journalists and campaigners and we launched ***The Lowdown*** to investigate policy decisions, challenge politicians and alert the public to what's happening to their NHS.

It is clear from the failures of recent years that we can't always rely on our leaders to take the right action or to be honest with us, so it is crucial to get to the truth and to get the public involved.

If you can, please help us to investigate, publicise and campaign around the crucial issues that will decide the future of our NHS, by making a donation today.

Our supporters have already helped us to research and expose:

- **unsafe staffing levels** across the country, the closure of NHS units and cuts in beds
- **shocking disrepair** in many hospitals and a social care system that needs urgent action, not yet more delays
- **privatisation in the NHS** - we track contracts and collect evidence about failures of private companies running NHS services.

First we must escape the Covid crisis and help our incredible NHS staff.

We are helping by reporting the facts around the lack of protective equipment for hospital staff but also for thousands of carers.

We are publishing evidence about more community testing and the shortcomings in our strategy to beat the virus.

Even though they have a tough job, there have been crucial failings: on testing, PPE and strategy and we must hold our politicians and challenge them to do better.

We rely on your support to carry out our investigations and get to the evidence. If you can, please make a regular donation, just a few pounds a month will help us keep working on behalf of the public and NHS staff - thank you.

We all feel such huge gratitude and respect for the commitment of NHS staff and it's so impressive to see such strong public support. Let's hope that we can give the NHS the thanks it deserves and crucially, secure its future.

With thanks and best wishes
from the team at the ***Lowdown***

Every donation counts!

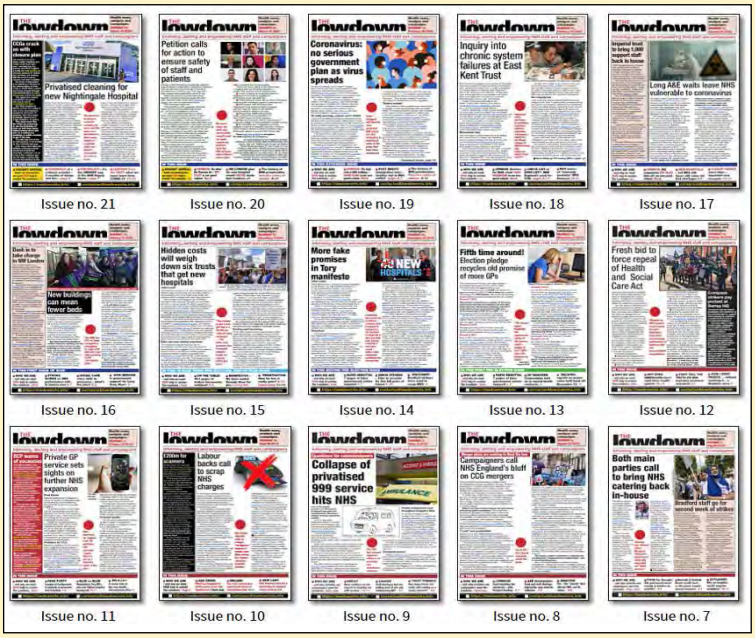
We know many readers are willing to make a contribution, but have not yet done so.

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*