THE lowdown

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

Expensive failures could cost lives

Up to 4,000 beds – but dependent on staff from other hospitals

John Lister

What links a network of rapidly-converted field hospitals, a family run food and beverages company in Antrim, a network of "super-labs", and Serco?

The final name has probably given it away: each of these is linked to a seemingly endless series of high-cost government or NHS blunders in awarding contracts related to the Covid-19 pandemic.

Market intelligence firm Tussell explains in a July Factsheet the way in which the Covid emergency has loosened the purse strings of the Department of Health and Social Care, and the ditching of even the requirement to tender – with details emerging only after the contracts have been signed off behind closed doors:

"While public procurement is usually guided by competition regulations, in emergency situations such as this the public sector are able to directly award contracts relevant to their response to the crisis."

Nightingales that didn't fly

This is how, with no public discussion of the viability or wisdom of the project, NHS England was able to award contracts in March worth up to £350m to set up and run the seven temporary "Nightingale" field hospitals in England for just three months – beginning with London, with later, smaller equivalents in Bristol, Birmingham, County Durham, Manchester, Harrogate and Exeter.

Only London (with a total of 51 patients) and Manchester treated any in-patients at all. Indeed the desperate shortage of appropriately trained staff meant that the Nightingales could only operate at all by stripping vital front line staff from existing mainstream hospitals. They could never open more fully, and were not considered suitable for the most serious Covid-19 patients.

Only the Harrogate and Exeter Nightingales, due to open this month, have any ongoing use – in delivering extra CT scanning capacity for the local NHS: the rest remain closed.

"We just cannot understand why the government paid £108m to two guys who run a pest control firm using public money. It's baffling."

PPE mystery contracts

While the Nightingale contracts could be deemed an excessive precaution, the award by the Ministry of Defence or the DHSC of a number of relatively large contracts for PPE procurement to obscure and clearly unqualified and inappropriate companies with few if any staff, no assets and no relevant experience has no such justification.

At least one of these contracts is now subject of a legal challenge. Barrister Jolyon Maugham told City A.M: "This is the most bizarre thing I've seen in my 25 years at the bar. We just cannot understand why the government paid £108m to two guys who run a pest control firm using public money. It's baffling."

Tussell is still suggesting that with the NHS spending up to £14 billion on PPE, while directly awarded contracts are still going anyone fancying a slice of the Covid action should "consider reaching out directly to public bodies to offer your services."

Tussell has helpfully highlighted a number of

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Expensive failures

from front page

cases where this has worked. They include contracts worth:

- £109m to Crisp Websites Limited (trading as PestFix),
- £108m to Antrim-based Clandeboye Agencies,

a family-run from which manufactures Crunch Craving nuts and offers "a range of goods and services from confectionery lines to coffee machine rentals,"

- £120m to Liverpool based P14 Medical Limited, a

firm with £78,000 assets and liabilities of almost £1.3m);

- and £25m to design company Luxe Lifestyle Ltd which

appears to have no employees, no assets and no turnover.

No doubt an eventual public inquiry will discover what, if anything, the government received in the way of PPE from this £350m of public money, who decided to award the contracts, and on what basis.

Not so super labs

The perverse government decision to set up a new network of Lighthouse 'super-labs' – rather than utilise and expand the existing network of accredited NHS and public sector laboratories to process samples from the Covid-19 testing centres – was first revealed in The Lowdown at the end of April.

However the extent of the government determination to build up a parallel private lab network without any proper links to public health or local NHS is still emerging, as are the worrying revelations of the failure of the Lighthouse labs to deliver timely data, and their poor standards and inefficiency.

On June 28 the Independent revealed the new part-privatised labs were often taking 72 hours from the time they received tests to determine a result – by which point the results were of no use for wider strategy or policy, while local NHS labs could give results in six hours.

This was followed by a whistleblower's report that dozens of shifts at one of the Lighthouse labs had been cancelled and staff paid to stay away because of a lack of test samples.

On July 2 The Guardian revealed plans to spend up to £5 billion over two years establishing a largely privatised expanded testing system, with expansion of the Lighthouse labs, and a further seven new commercially run laboratories to be added, potentially rising to as many as 29, "one for each NHS pathology region in England".

Serco fails again

In May Serco, the company with a long line of NHS contract failures, whose former lobbyist Edward Argar is now a junior health minister, won the contract worth up to £90m for tracing contacts of people testing Covid-positive.

There were early warnings of inadequate training of call centre staff and shambolic systems, with the private firm Sitel, also given a smaller contract to cover the work, reportedly doing no better.

Serco's chief executive revealed that he doubted the scheme would evolve smoothly but admitted he wanted the contract to "cement the position of the private sector" in the NHS supply chain. It was admitted that the system would not be fully functional until the autumn.

By June 19 it was revealed that the "world beating" system was failing to contact a quarter of people testing positive and a poll showed only half the public trusted the company to deliver.

Figures showed the privatised system, with 25,000 mainly low paid staff, had contacted fewer than 10,000 of the 87,000 close contacts of Covid positive people – the bulk of successful contacts being delivered by local public health protection teams.

The issue in these continuing failures, from which no lessons appear to be learnt, is much more than the government's ideological fixation on the private sector or the potential waste of tens or hundreds of millions in public funds: with lockdown being relaxed, the failure of contact tracing, like the failure to establish swift and reliable testing, and inadequate supply of PPE can put lives at risk.

£1m to set up lab project – but still no business case

Over £1 million has been spent so far on developing a Business Case for centralising pathology services in Lancashire covering four NHS trusts, according to information released under the Freedom of Information Act.

The request for disclosure was submitted by Unite shop steward Cllr Jonathan "Jono" Grisdale, as the union remains concerned at the implication both for jobs and for potential delays and problems in the resulting service if the centralisation goes ahead.

Back in May the Lowdown reported that the plans to drive through the merger of four NHS hospital laboratories serving a population of 500,000 people in Lancashire and South Cumbria (Blackburn, Blackpool, Lancaster and Preston) into a single hub in Lancaster, were being progressed "under the radar" of the Covid pandemic.

The initial proposals, first raised in 2016, had been put on hold last year awaiting allocation of the required funding, delaying possible implementation from the original target date of 2021 to at least 2024.

Now the FoI response from the Pathology Collaboration project reveals that in addition to extensive time and effort of salaried Board members and other staff, the salaries of the operational project team totted up to £512,000 in the 30 months to September 30 2018 – and another £615,250 in the 15 months to December 2019.

However despite more than £1.1m outlay in almost 4 years, no business plan has yet been produced. The FoI response notes "There is a large number of staff either directly or indirectly involved in the project" and the project is advertising for a Finance Manager at Salary Band 8b (£53-62k): so whether this involvement has been productive or value for money remains to be seen.

The promised £31m to underwrite the costs of the centralisation will only be released after the production and approval by NHS Improvement and DHSC of a Strategic Outline Case and Business Outline Case.

Even now they are flying beneath the radar it seems the progress towards this is slow, and the project could be overtaken by the rumoured plan to establish of a new national network of 29 commercially-run pathology labs.

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Homerton trust board sticks with outsourcing giant

Homerton hospital health workers take the knee before heading over to join a Stand Up To Racism vigil outside the hospital.

George Binette

DESPITE MOUNTING OPPOSITION the Board of Directors at Homerton University Hospital Foundation Trust (HUHFT) in Hackney, east London looks set to ink a further five-year contract for 'soft facility' management with Danish-based multinational ISS later this month (July) without a competitive tendering exercise.

Citing a supposed lack of 'bandwidth', HUHFT Chief Executive Tracey Fletcher has defied widespread calls from unions, local politicians and Hackney residents, as well as some Trust governors and scores of the Homerton's own doctors, to move towards insourcing the 300-strong workforce of cleaners, porters, catering and reception/security staff.

ISS-Mediclean originally secured the Homerton facility management contract, valued at more than £45 million, in 2015.

The five-year deal was set to expire on 30 September. The 2015 agreement included an ostensible commitment to ensure that the London Living Wage (LLW) would be the minimum hourly rate on the contract, but by 2017 a substantial part of the workforce, which had TUPE transferred from another private firm (Medirest) had seen their wage rates fall behind.

For more than two years these workers received less than LLW and while this is no longer the case there is still an issue of back pay, in some cases amounting to more than £2,000.

No occupational sick pay

Nearly 80% of the HUHFT ISS workforce comes from Black and other ethnic minority groups. Many of these workers have no contractual right to occupational sick pay and would normally only receive statutory sick pay of just £95.85 a week with no pay at all for the first three days of sickness absence.

In recent evidence to Hackney Council's Health in Hackney Scrutiny Commission, University of Newcastle professor and Independent SAGE member, Allyson Pollock, noted the importance of "full financial protection" for all staff working in a hospital setting as a key tool in infection control.

Faced with union pressure ISS did concede sick pay from day one for those obliged to self-isolate midst the Covid crisis, but this arrangement was only temporary and the issue's relevance goes beyond the immediate context of a global pandemic.

With workers facing an ugly choice between working while unwell or scraping by on woefully inadequate pay, there are obvious implications for both worker and patient safety.

And yet there is still no commitment to ensure that occupational sick pay for the whole workforce features in the new contract. In fact, senior Trust management have suggested that they are reluctant to incorporate it for fear that it will encourage absenteeism!

Beyond the issue of sick pay, there remains a yawning gap between ISS employees and directly employed NHS staff.

Typically, an ISS employee working full-time would earn some £1,500 less a year than someone on the lowest pay band on an Agenda for Change employment contract - and that's before considering the absence of enhanced rates for overtime and anti-social hours.

Bring staff in house

Last autumn both the GMB and Unison launched campaigns, which swiftly merged, to bring the ISS workforce 'in house' on Agenda for Change contracts.

Inevitably, the Covid crisis dramatically curtailed public campaigning after early March, though unions and Labour Party activists are again working to raise the profile of opposition to the HUHFT Board's decision.

The Trust Board, meanwhile, is keen to publicise the hospital's recent 'outstanding' rating from the Care Quality Commission, which, of course, pays no heed to the reality facing a substantial proportion of the Homerton-based workforce.

Since Margaret Thatcher's second term the outsourcing of NHS ancillary staff has become the norm and the privatisation of jobs often held by BAME workers has often been overlooked midst concerns about the wider marketisation and dismantling of the NHS.

But the Covid pandemic has served as a potent reminder that these are indeed key workers, who should be truly integrated members of the 'NHS family'.

This means that the fight both at the Homerton and nationally must intensify to win full Agenda for Change pay and conditions for these workers and to ensure that Covid does not serve as a cloak for cash-strapped Trusts to continue feeding such outsourcing giants as ISS.

ISS did concede sick pay from day one for those obliged to self-isolate midst the Covid crisis, but this arrangement was only temporary

■ *George Binette is Hackney North & Stoke Newington Constituency Labour Party Trade Union Liaison Officer*

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Celebrate the NHS – and protect it

Martin Shelley

In an increasingly polarised country like modern-day Britain, prey as it is to the twin challenges of Brexit and covid-19, few institutions offer the reassuring sense of social cohesion that the National Health Service (NHS) represents today.

Under threat from ideology-driven re-organisations and cost-cutting initiatives almost from day one (even back as far as 1956, when Winston Churchill and his fellow Tories were said to be furious, because the report they'd commissioned was unable to come up with a more efficient alternative), the NHS is still with us after 72 years and still very much part of the fabric of everyday life in this country.

And the post-war Labour government health secretary Aneurin Bevan's statement of intent – "No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means" – remains as powerful and relevant today as it did during the early post-war years.

Certainly, since its inception the NHS has undoubtedly gone on to play a pivotal role in improving the nation's health, right up to the present day.

Life expectancy between 1948 and 2020, for both males and females, has improved by more than ten years, while infant mortality – deaths per 1,000 live births – has plummeted over the same period.

Mass immunisation programmes have largely banished diseases like diphtheria, and smallpox. Health campaigns have led to a huge drop in cigarette smoking.

Contraceptive pills and abortions became available during the 1960s, and rapid advances over the following decades saw the introduction of heart and other organ transplants, together with IVF treatment, keyhole surgery and CT and MRI scanning, as well as free mammograms.

And although access to long term care, dental work and spectacles is far more limited; GPs, health clinics and hospital services all remain free, while the NHS has become one of the world's largest employers.

Bevan's statement of intent – "No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means" – remains powerful and relevant

65 lanterns were lit – one per 1000 excess deaths since Covid pandemic – in a silent vigil on July 3. A procession from St Thomas' Hospital led by NHS staff crossed Westminster Bridge to Downing St, challenging government failures. The names of over 300 NHS workers who lost their lives caring for C19 patients, were read out

London Olympics

Its cultural and social importance was famously celebrated in the Danny Boyle-designed opening ceremony of the London 2012 Olympics, despite the reported displeasure of the then culture secretary Jeremy Hunt.

And who can ignore the almost constant presence in the TV schedules of nurse- and doctor-related dramas and documentaries?

Call the Midwife, Casualty and Holby City are all prime-time viewing and reflect the universal affection people have for the work of the NHS.

Public interest and support for the NHS was clearly demonstrated when local health service fundraising group NHS Charities Together raised more than £90m for its covid-19 appeal.

But no matter how much money is raised through public appeals, state funding of the NHS is central to its existence,

Government-imposed funding constraints over the past decade have steadily undermined the capacity and efficiency of the NHS and prior to the Covid crisis the NHS had just published its worst performance figures, with record waits for cancer treatment and delays in A&E.

Last November, research by the Labour Party showed that almost 80,000 urgent or elective operations had been cancelled over the previous 12 months due to staff shortages and equipment failures.

'Trolley waits' and 'corridor nursing' are phrases that have become part of every newspaper sub-editor's lexicon, resurrected each winter to describe the scenes in A&E departments across the country.

Four years to recover

Now, after all the efforts in fighting the first wave, hospital bosses have warned it will take up to four years for the NHS to get back to providing its full range of services because of the huge disruption caused by covid-19.

The number of patients waiting for a planned operation could rise from 4.2m to as high as 10m by the end of 2020.

Meanwhile the government's strategy during the pandemic of relying on private contractors – is increasingly transparent, and follows ten years of NHS and local government reorganisation and funding constraints.

One academic, also a former regional director of public health in the NHS, told the Guardian, "There

This July 4 event to mark the NHS 72nd anniversary was one of over 20 local events organised by Keep Our NHS Public. It was followed on the Sunday by an afternoon online rally that was viewed live by 33,000 on Facebook, Twitter and Youtube

has been a destruction of the infrastructure that stops England coping with major emergencies. It absolutely explains why you're now seeing private companies being brought into these functions."

Moves to centralise purchasing functions within the NHS confirmed the suspicion of many campaigners and medical professionals that the government is using the pandemic to transfer key public health duties from the health service and other state bodies to the private sector.

The Guardian reported that centralising purchasing of crucial items such as PPE and ventilators during the pandemic was likely to lead to more functions being handled by management consultancy Deloitte rather than directly by NHS trusts, with stock information then being gathered by US data mining group Palantir.

Deloitte was also revealed to be co-ordinating three new 'Lighthouse' test centres, assuming responsibility for testing previously handled by NHS-accredited laboratories.

This, despite a recent study that showed NHS trusts which hire management consultants to cut costs can end up spending more.

Health and Social Care Act

Some commentators consider the government's current policy of 'private good, public bad' when it comes to health service provision stems from the passing of the 2012 Health & Social Care Act, which gave private companies the green light to extract profits from the health and social care sector (and which many working in the NHS now think should be reviewed).

Since the Act hit the statute books the number of NHS beds has actually fallen by 5 per cent, private care home providers have been awarded £1.5bn, and PFI contracts have paid out almost £1bn that should have been retained within the health service.

The Act also saw the transfer of public health duties – central to the current response to the pandemic – from the NHS to local government, a sector which has suffered cuts of £850m in central government grants over the past six years.

This loss of income has obviously had an impact. In 2018, on the occasion of the NHS' 70th birthday, the BBC commissioned a 'How good is the NHS?' report that found unusually good financial protection to the public from the consequences of ill health, it was relatively efficient and performed well in managing patients with long-term conditions, despite an "unusually low level of staffing and… equipment". However, it performed worse than average, relative to other wealthy countries, in the treatment of eight out of the 12 most common causes of death.

It was also the third-worst performer on the rate at which people die when successful medical care could have saved their lives, and it had consistently higher rates of death for babies at birth or just after birth.

A US survey in 2018 showed that more Americans were afraid of paying for healthcare if they became seriously ill than were afraid of getting seriously ill.

Horrors of American health care

But in the post-Brexit era – when many in the UK fear the NHS could soon be "up for sale" to US interests, despite repeated government denials – it's timely to put that BBC report into perspective by glancing across the Atlantic to see how the patient experience there differs from our own, under a system that isn't funded centrally through taxation.

In 2018, the same year as the BBC report appeared, almost 28m people in the US had no medical insurance at all in a country where the healthcare system is largely dependent on the financial services sector for its very existence.

A US survey in 2018 showed that more Americans were afraid of paying for healthcare if they became seriously ill than were afraid of getting seriously ill.

Another survey a year later revealed that, over the previous decade, 30 per cent of US citizens had delayed seeking any sort of medical treatment at all because of the prohibitive cost.

Hardly surprising, given that one 70-year-old Seattle resident, recently recovered from covid-19, was presented with a hospital bill of $1.1m earlier this year.

Rolling back Obamacare

Meanwhile, for the past three years Donald Trump has been trying to overturn the Affordable Care Act (commonly known as Obamacare, and hardly the dangerous experiment in socialism it's often made out to be in the right-wing US media).

Now Trump, under cover of the rapidly deteriorating covid-19 situation in the US,is pressing the Supreme Court to terminate the Act. If he's successful, that means millions of Americans who have survived Covid-19 or face future infections could lose their insurance, or even be barred from getting coverage.

Clearly, the US experience is something to avoid, and presents a strong case for retaining and bolstering the NHS in its present form, especially at a time of increasing social polarisation and encroachment by commercial interests.

We must cherish and defend it at all costs.

Could a national care service help solve the social care crisis?

Paul Evans

Social care services are in even greater peril as figures show that councils are battling huge debts and scores of providers are selling up. The public services union, UNISON has renewed the call for a national care service, releasing a strategy document, Care after Covid, to make the case for a radical shakeup.

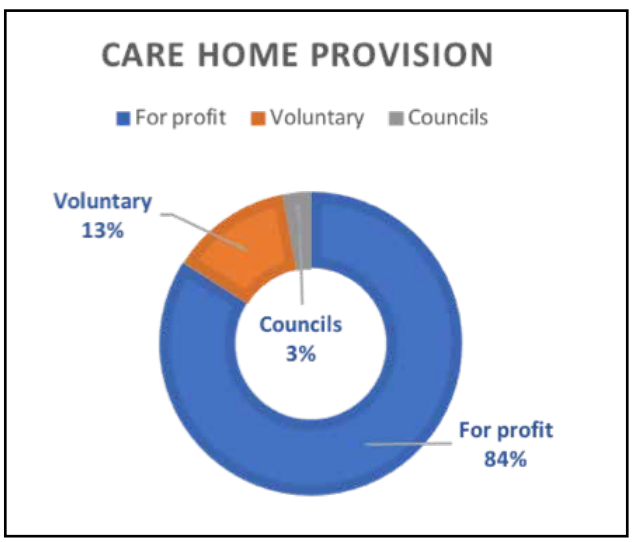
A national care service is not a new concept, appearing in the 2010 Labour manifesto and again in 2017, although on this week's Andrew Marr show, Labour's Shadow Chancellor- Anneliese Dodds seemed less certain about the commitment; elsewhere a host of commentators and organisations are now backing the return to a more publicly driven structure.

This latest exploration of the idea by UNISON links past and present, making the case that Covid-19 has cruelly exposed the vulnerabilities in our care system that grew from a decade of austerity and from privatisations that started in the 1980s.

Pandemic failings

Whilst NHS staff were heroes from the start, care workers struggled to get basic support. UNISON reported that during the crisis that many care staff couldn't take time off to self-isolate because of "poverty pay" in the sector. Others were denied sick pay by their employers whilst isolating, or were pressured to come in to work.

Access to proper PPE has been a scandal throughout, and care workers were heavily exposed, but in a sector with 8000 businesses a coordinated response to Covid was almost impossible. The inability to collect standardised data about the number of deaths and infection rates in care homes highlighted the flaws in a system run by businesses operating individually, when collaboration was key to responding to the virus.



Many care staff couldn't take time off to self-isolate because of "poverty pay" in the sector. Others were denied sick pay by their employers whilst isolating, or were pressured to come in to work.

A new mission

UNISON's strategy aspires to bring back inhouse care sector staff and facilities, eventually "fully integrating" with the NHS and delivering the vast majority of social care through public funding; but the union acknowledges the current reality that 97% of care is delivered by private or voluntary organisations, which means the transition to national care service will take time.

The report does not venture into how much this would cost, or set a timetable, but it does identify steps that could be taken straight away.

The government needs to lift overall spending on social care by £12.2bn to 2022/23 - based on estimates by the Health Foundation and this funding should be aimed at the 1.5 million people who Age UK say aren't receiving care at the moment, but also invested in the workforce that is estimated to be short of 122,000 staff.

Funding for councils - to start to invest in bringing services back in-house, would allow for the development of training and pay that is standardised and fair, right across the sector.

UNISON asserts that, as a society we need to think about social care differently: "as no longer just a "cost" but an important economic sector, with investment in it helping to rebuild local economies" in the wake of Covid-19.

The New Economics Foundation, who have published their own analysis of care sector ownership agree, calling for universal care services, like the NHS : "The choice facing policymakers, both local and national, is whether to let services continue to develop in a way that is extractive, drives inequality through low-paid, insecure jobs, and puts downward pressure on the quality of care, or to intervene."

Driven by cost

Much of the evidence confirms that the current system regularly fails to meet the needs of patients, a reality epitomised by the rigid 15-minute standard for home care visits. Care staff employed by companies work to the clock, restricted in the time that they can spend with each client, whereas community nurses working for the NHS, although working under pressure, have more freedom to adapt to the needs of the patients they visit.

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However, the underfunding of councils has exacerbated the crisis, resulting in low-cost deals with providers and in unison's view, price has is steering decisions about care, and they say most councils are "failing to pay the minimum amount considered necessary to provide safe levels of care."

"As of January 2020, there were 30 councils paying less than £500 per week for an older person in a residential care home, equivalent to just £2.97 per hour"

Changing ownership

This is a tight market and many providers are fighting for survival. Last year three-quarters of councils reported that providers in their area had closed, ceased trading or handed back publicly funded contracts.

For private equity this is an opportunity. Market conditions are shifting the ownership of home care providers as the small players sell up to firms backed by investment groups.

The largest four residential care companies provide 15% of residential, and just under a third (31%) of all beds are provided by the biggest 25 companies.

This hasn't provided stability, in recent times two of the dominant players, Southern Cross in 2011 and Four Seasons in 2019 have gone into administration with councils under pressure to protect vulnerable residents.

High borrowing, low staff pay and sharp cost controls are key features of the for-profit model, said Grace Blakeley, co-author of an IPPR report, which calls for the state to once again become a major provider of care homes by investing £7.5bn to provide 75,000 beds by 2030.

"The fact that private equity-backed firms have taken over a significant share of the UK's care provision… puts our social care system at risk"

"The fact that private equity-backed firms have taken over a significant share of the UK's care provision, fuelled by debt and driven by the prospect of rising property prices and ever-lower care costs, puts our vital social care system at ever-increasing risk,"

The IPPR report also indicates the scale of the challenge to bring back all care beds into public hands, as their plan which would still leave around two thirds of beds being run by the independent sector. Figures produced by IPPR and Future Care Capital show that for-profit companies currently own 381,524 (83.6%) of England's 456,545 care home beds.

However, the status quo is unsustainable. The New Economics Foundation suggests that the current government response, of producing sporadic extra funding without reform could be "propping up" a system, which increasingly channels public funds to big corporates.

Urgency as cuts approach

The current system also looks near to collapse as the rising costs shouldered by councils cannot continue to be supported. Despite an extra £3.7bn in Co-vid related funding from the government the Local Government Association see a blackhole of £7bn and research by the BBC and CPP has discovered many councils are confronting deficits and a number are on the edge of bankruptcy.

Adult social care costs make up over 40% of council expenditure, pressing down on other budgets and several councils are already reported to be working on packages of cuts. Leeds City council is freezing recruitment and all non-essential spending and Luton, Manchester, Wiltshire and Liverpool have also raised concern about their finances.

Despite recent funding, the trend has been to cut spending in real terms. The IFS calculate that austerity measures nationally have driven down spending on adult social care by 7% per person in the past decade.

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- 1.5 million people aren't receiving care at the moment - (CQC)
- Social care services are short of 122,000 staff, which could double by 2030 - (Health Foundation)
- Returning to peak spending levels, (2010/11) and increasing pay would cost around £12.2bn. - (Health Foundation)
- Adult social care accounts for around 40% of council spending

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Social care crisis continued from page 7

Low pay and poor standards

Unsurprisingly low pay and poor working conditions are prevalent. A quarter of care staff are employed on zero-hours contracts. There is a big turnover, a third of care staff leave their roles each year and there is a major shortfall of 120,000 staff, which could double by 2030.

Not all parts of the UK currently have professional registration for care workers, and changing that is Unison say, is one way of ensuring a more consistent approach to standards and boosting the prestige of care work.

Inadequate across the UK

All four home nations view their social care systems as inadequate and are looking towards reform, but there are already significant differences, most notably in Northern Ireland where health and social care have been fully integrated.

All four make use of means-testing to control access, but as a Nuffield Trust article points out the funding offer in England is the least generous: "Scotland has free personal care, Wales operates a weekly cap on non-residential care costs, and Northern Ireland provides domiciliary care services free of charge."

How to get there?

Few are suggesting a rapid transition to public ownership, perhaps due to the immediate cost and the total dominance of the private sector, but the New Economics Foundation suggest ways to start the process: by giving local authorities new powers to buyout providers that are failing or consistently providing poor quality care and, crucially to provide new sources of finance. Government should, NEF say, promote cooperatives and provide employees with first refusal to buyout care providers as businesses come up for sale.

The NEF also suggested bolstering the Care Act 2014 to place a duty on local authorities to "promote diverse forms of democratic ownership across domiciliary and residential social care provision", as a counter to the market.

Of course, the market intended to provide choice, but its failure should prompt us to change tack, to involve the public and organisations in commissioning to make it "collaborative rather than competitive".

Promises of actions

Boris Johnson promised to "fix social care once and for all" in England.

After the last election he backed this up with a pledge to provide a plan for solving social care within a year and to introduce changes by 2025.

We are still waiting for his plan, but there are more reasons than ever to leave behind an era of failed market based-solutions.

Will NHS England block plan to halve bed numbers?

John Lister

Health chiefs in Merton and Sutton CCGs have agreed without serious debate to press ahead with a controversial project which would halve the number of acute beds provided by Epsom & St Helier University Hospitals Trust.

Under the ridiculously misnamed 'Improving Healthcare Together' (IHT) plan, the existing Epsom and St Helier Hospitals would be downgraded, their A&E units reduced to urgent treatment centres, and downsized, with a severely reduced number of beds, no longer designated as acute but as step-down "district hospital" beds; instead a new £400m+ hospital would be built in Sutton.

All specialist emergency and elective services and all of the consultants would be centred at the new Sutton Hospital, which is planned to hold a nominal 520 beds, although just 387 of these would be front line acute beds – down from over 750 available in the trust during the 2019-20 winter.

The Decision Making Business Case, backed by the Epsom & St Helier trust board, has now been nodded through by CCGs, despite the opposition of both of the local authorities, the London boroughs of Merton and Sutton.

Epsom and St Helier hospitals are again under threat

Nonsense

The plan also makes a nonsense of the recent launch of a South West London Integrated Care System. Not only is the ICS supposed to build "partnerships" with local government, but it appears that the ICS has taken no view or maybe even not been consulted on the IHT plan.

The only published plans for the ICS so far are based on the 2016 Sustainability of Transformation Plan, which stated clearly that:

"South West London STP will continue to need all of the hospitals it currently has, but does not believe that every hospital has to provide every service. … The immediate focus is on getting primary care and services in the community right."

However ICS Independent Chair Millie Banerjee has not responded to a letter from Merton & Sutton TUC, and expressed no public view on the IHT plan – effectively nodding it through.

Unions have pointed out that reduction in acute bed capacity flies in the face of explicit NHS England guidance earlier this year even prior to the Covid crisis calling for an end to reductions of acute bed numbers.

The IHT plan would slash bed numbers AND dispose of land and buildings at Epsom & St Helier – as the NHS faces the problem of relaunching elective inpatient services with social distancing, and the reduced use of capacity putting space at a premium.

Post-Covid

Indeed more recent NHS England guidance, looking forward to a post-Covid situation, is even more categorical.

NHS England/Improvement's estates chief Simon Corben has called for trusts to reduce the amount of non-clinical space by converting it to "surge capacity" to deal with winter pressures and a possible second peak in Covid cases: Epsom & St Helier trust bosses on the other hand are determined to sell off any spare space.

Speaking about the government's plans for new hospitals, which include funding for Epsom & St Helier, Mr Corben said it was "paramount" that lessons learned from covid-19 were "captured" when designing the new facilities.

"We must use covid-19 as an opportunity to design facilities that give us resilience going forward," he said.

The fight goes on to stop the juggernaut: but will NHS England take its own guidance seriously and knock back the most advanced of the plans for new hospitals, or make itself look ridiculous by nodding them through?

Sizing-up Johnson's builder credentials

Croydon's new Emergency department looks good – but the hospital's bed shortage is unresolved, and A&E performance well below target

Sylvia Davidson

There will be £1.5bn extra this year for NHS building and maintenance projects, according to Boris Johnson, in his speech in Dudley on 29 June, outlining measures to help the UK through the economic shock of the coronavirus pandemic.

The £1.5bn is part of the "£5bn of capital investment projects, supporting jobs and the economic recovery".

On closer inspection, most of the promises in the speech - on houses, schools and roads - have turned out to be money or schemes that had already been announced in the March budget.

The £1.5 bn for the NHS will be added on to the capital budget and will be used "hospital maintenance, eradicating mental health dormitories, enabling hospital building, and improving A&E capacity." according to the government statement.

New money?

In the case of the NHS, the £1.5 bn is new money on top of the planned capital spending for the Department of Health and Social Care for 2020-21 increasing it from £8.2bn to £9.7bn this year, but its impact will be very limited indeed.

The government's own figures give the cost to eradicate the current backlog in maintenance of NHS premises as £6.5 billion. This figure does not include planned maintenance work, rather, it is work that should already have taken place.

Add on to this the costs of converting NHS premises to reduce the risk of coronavirus infection, and it is clear the £1.5bn falls well short of what is needed.

New hospitals?

Then, there is also the issue of the 40 'new hospitals', promised back in September 2019 and a major feature of the 2019 election, and when questioned Johnson said they had not been forgotten: "Matt Hancock is setting out the list in the next few days, and that is just the beginning."

What has also not been forgotten is that the 40 'new hospitals' turned out to be £2.7 billion to fund just SIX new or refurbished hospital projects. £100 million is also provided as "seed funding" for 21 trusts to draw up plans for another 34 hospital projects – which will potentially cost another £10 billion or more – after 2025.

Back in November 2019, The Lowdown reported that none of the six new hospitals that have been given the "immediate" go-ahead is actually near ready to start work.

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Community beds?

Finally, another call on the £1.5 bn could be the creation of hundreds of new community beds.

On the day of Johnson's Dudley speech, the HSJ reported on possible plans to increase the number of community-based rehabilitation beds for patients recovering from coronavirus and respiratory illnesses across England.

This would see regions competing with each other for money from the capital budget, according to the HSJ report.

The NHS in the North West of England has been asked to increase the number of community-based beds by 900, according to the HSJ, which would alone cost tens of millions of pounds to deliver.

Steep challenge

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

NHS trusts have also been forced to raid the capital budget for day-to-day running expenses.

One-off pots of money are always welcome, but what NHS leaders want is a multi-year capital budget that allows them to plan into the future.

Saffron Cordery, deputy chief executive of NHS Providers, which represents NHS trusts:

"What trust leaders need is a multi-year capital budget, bringing expenditure into line with comparable economies, that allows them to plan for the future. This should be part of a proper spending review process encompassing other vital and long-overlooked issues including education and training and public health."

Anita Charlesworth, director of research and the REAL Centre (Research and Economic Analysis for the Long term) at the Health Foundation, said that the NHS needed "a clear plan for long term investment" because the funding announced by the government "will only go a short way to addressing years of underinvestment."

Professor Donal O'Donoghue, Royal College of Physicians registrar said: "But while new pots of one-off funding are welcome, what the NHS really needs right now is a sustainable funding package to support and grow the NHS workforce."

Discussion begins on 'NHS Reset'

Top NHS managers want post-Covid change – but not much of it

John Lister

Senior NHS managers have been working out what they want to see as the next steps in restarting more normal mix of services in the post-Covid situation. One thing is clear: few seem to want to see the NHS flip back to the system that prevailed before the virus hit at the beginning of the year.

The Health Financial Management Association (HFMA) has published 20-page discussion paper ***The future NHS financial regime in England***, which notes the potential to "redesign the national health and social care system from an almost blank sheet of paper."

Only a minority of the HFMA members surveyed seem to favour a return to the system of commissioning and contracting for services that was established by the disastrous 2012 Health and Social Care Act.

It seems they want to change almost everything – but not enough to make a real difference.

One common factor between the HFMA and the NHS Confederation (which represents commissioners as well as providers) is their fear for the financial squeeze to come.

The HFMA bluntly sums up the looming problem:

"As the country emerges from the immediate needs of the Covid-19 pandemic, finances will once again become constrained. These constraints could be significant with the Bank of England warning of the sharpest recession for 300 years." (p5)

The NHS Confederation document ***Getting the NHS back on track*** also states the problem clearly:

"The recent short-term financial commitments to support providers, including the coronavirus emergency response fund and the 'writing off' of provider debt, have been welcomed, but they have not addressed many of the underlying financial challenges. The position according to many of our members in secondary care is that their financial position is rapidly deteriorating." (p7)

By contrast the equivalent report from NHS Providers ("Recovery Position") is strangely silent on the financial challenges to come, and their most recent blog on finance is a studied mixture of vague statements, evasion, and ambiguity, while admitting the obvious fact that:

"The financial assumptions made by systems and national leaders about 2020/21, and therefore every subsequent year of the long term plan period, are now obsolete. Moreover, providers' costs have changed significantly following COVID-19 service reconfigurations, and are unlikely to go back to "normal" in the foreseeable future."

None of these management organisations apparently wants to engage with a major issue of capacity going forward – most notably the undisclosed, but extremely high, number of NHS acute beds that remain closed after they were emptied of patients back in March to create scope to treat Covid-19 patients.

"The financial assumptions made by systems and national leaders about 2020/21, and therefore every subsequent year of the long term plan period, are now obsolete"

Unused NHS beds

In mid April the *HSJ* saw leaked figures revealing 40% of acute beds (over 37,000) were unoccupied: NHS England has refused to share any more recent figures with ***The Lowdown,*** and a Freedom of Information request has been submitted.

With these beds out of action it appears everyone is in agreement with signing a huge and costly long term deal for the NHS to use up to 8,000 private hospital beds as the first step to tackling a soaring waiting list and resuming a more normal balance of services.

The *Guardian* has reported this could involve spending up to £5 billion – to the consternation of the Treasury which has sent NHS bosses away last month to reconsider.

However there seems to be little or no discussion amongst NHS leaders on what the consequences of any such deal could be for trusts. They stand to lose this income – but would quite likely have to provide the staff to deliver the treatment, leaving their own services short-staffed as well as their own beds closed for many more months to come.

So what changes do the discussion documents want to see?

The HFMA wants to see a change of financial regime and a change in organisation to establish Integrated Care Systems at local level.

It also calls for action to tackle underfunding of social care, and "further Covid-19 capital investment" to ensure that sites are able to deliver appropriate social distancing.

The end of cost per case?

On financial regime the HFMA reports that its members are looking to move beyond the controversial (and currently suspended) Payment by Results (PbR) system which effectively pays acute hospitals per patient treated on a cost-per case basis linked to a national tariff:

"From the survey responses, there is no appetite for a cost per case contract model from any sector within the NHS, although a method is clearly needed to enable calculation of the correct baseline contract."

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Cheltenham Hospital: its future in doubt under pre-Covid plans – will the new situation for a rethink?

The NHS Confederation's May report *STP One Year to Go* also shows managers looking for similar changes, and quotes an unnamed STP Director of Strategy saying:

"At last PbR has been forced out. It will be interesting to see what happens about that coming back. If [NHSEI] lets those rules go back into position and we go back to PbR then… you can't have an integrated care system with PbR. It is not part of what we're trying to achieve."

An additional factor is that restoring PbR, reverting to paying hospitals per patient treated, at a time when Covid restrictions are likely to reduce NHS acute hospitals to 60-70% of their capacity, would spell financial ruin for trusts – especially those with high fixed overheads in costly PFI contracts.

However scrapping PbR would unpick one of the mechanisms brought in by New Labour in the mid 2000s as a basis to create a health care "market", opening up the NHS budget to private providers of clinical care.

Integrated Care Systems

NHS England's Long Term Plan in January 2019 sought to replace competition between NHS providers with collaboration, and in this way to at least partially unpick the "purchaser-provider split," which was first established in 1990 when Margaret Thatcher's "internal market" established NHS trusts as separate bodies.

Last autumn NHS England requested government action to change the 2012 Health and Social Care Act, to allow greater decision making by joint committees spanning different commissioners and providers.

Even without the legislation they have proceeded to do this anyway, ignoring the letter of the law, and 18 so-called Integrated Care Systems (ICSs) have now been established, in which in theory the boundaries between commissioners and purchasers are blurred – but there is little if any public accountability.

NHS England stopped short of calling for ICSs to be created as statutory organisations – which would open up the question of accountability to local communities, and undermine the autonomy of foundation trusts.

Now the HFMA argues for a faster spread of ICSs, implying a restricted role, if any, for Clinical Commissioning Groups (CCGs):

"Progress towards integrated care systems should be speeded up and more devolved decision making enabled at a local level. The commissioning function should focus on strategic commissioning in order to improve population health and to strengthen system working."

Eliminating competition and bringing providers and commissioners into "Integrated Care Systems" certainly raises the question of what role is left for the CCGs as commissioners. The HFMA (which includes CCG finance directors) appears agnostic on this, but notes "Some respondents to the survey see this as an opportunity to review the local commissioner role and the purchaser/ provider split."

The NHS Confederation, on the other hand, seems much more willing to envisage statutory ICSs and the demise of CCGs. Its report (*Time to be radical? The view from system leaders on the future of "system by default*) is based on survey findings, which include 63% agreeing that the health and care sectors should be integrated on a statutory rather than voluntary basis.

The same survey found a majority in favour of CCGs being subsumed and commissioning taken over by ICSs, with only a minority holding out against this:

"… just over two thirds of system leaders considered that strategic commissioning should move to ICSs at system or place level. However, a quarter disagreed …" (p10)

Private sector

The HFMA makes only one passing reference to the notion of partnership with the private sector, in contrast to the NHS Confederation, which includes private sector providers, and is much more up front in favouring a strategic inclusion of private providers as "equal partners" in the rebuilding of the NHS, arguing:

"There is an opportunity now to reset this set of relationships and to regard the NHS, local government, private and voluntary, community and social enterprise organisations all as equal partners during the next phase of the recovery." (p5)

And while reopening up the 37,000 unoccupied NHS beds is not mentioned, the importance of the 8,000 private hospital beds is stressed, with the Confed putting it top of their list of "Practical solutions":

"Putting in place ongoing arrangements with the private sector to provide the health service with the capacity to deal with the major backlog of treatment that has built up since COVID-19." (p10).

As management bodies, think tanks and others continue to churn around ideas in a new situation, it's clear campaigners' calls for reversal of the damaging proposals of the 2012 Health and Social Care Act are being grudgingly embraced, even if in distorted and diluted form, by many in the NHS.

However it's also clear that more pressure is still needed to ensure the outcome of this confused and halting process is not a new bureaucratic stitch-up, with renewed or extended links with private contractors and providers, but genuinely integrated, publicly provided health care that is accountable at local level.

"There is an opportunity now to reset this set of relationships and to regard the NHS, local government, private and voluntary, community and social enterprise organisations all as equal partners… "

Please donate to help support our campaigning NHS research and journalism

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.

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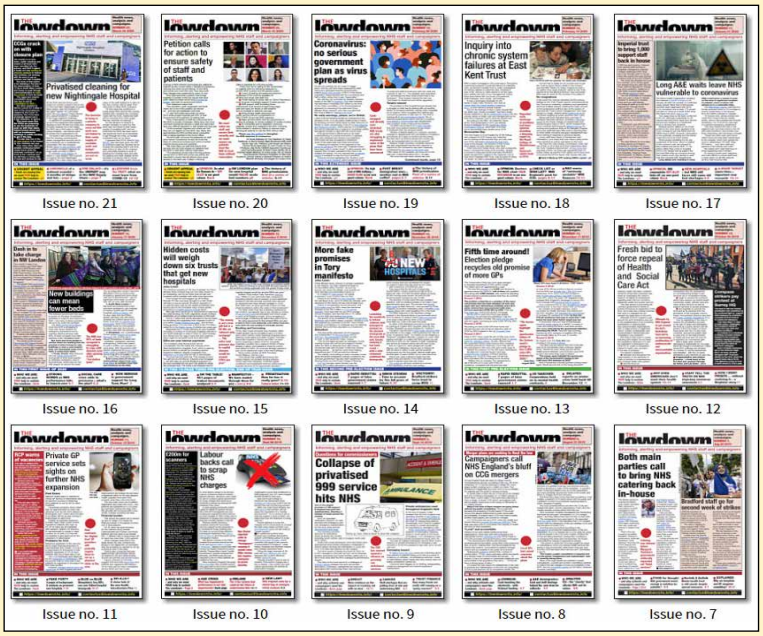

● If you have any other queries or suggestions for stories we should be covering, contact us at *contactus@lowdownnhs.info*