The lowdown

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

Dark side of the 'moonshot' exposed

Almost three in four people think private contractors Serco and Sitel should lose their role running the NHS Test and Trace operation, according to a Survation poll, as evidence mounts of serial incompetence, widespread non-availability of covid-19 tests, software failures sending people on ridiculous long journeys for tests, and lengthening delays in getting test results.

But Tory peer Dido Harding, appointed as "testing tsar" by health secretary Matt Hancock, has "strongly refuted" claims the system is failing. She also confesses to having been surprised by the "unexpected" increased demand for testing after schools and universities reopened, people were urged to go back to work, and more restrictions were lifted.

Lighthouses fail to shine

The failures of Serco and Sitel have been compounded by delays and failures in the five part-privatised Lighthouse laboratory network which ministers set up rather than expanding the existing network of NHS and public health labs.

A sixth Lighthouse lab in Newport has been delayed, and a seventh is due to open next month – ignoring warnings from the Institute of Biomedical Science that the labs have become "a parallel but disconnected testing stream for covid-19", and have "failed to deliver robust data". The institute warned in June that "Links with clinical systems are still poor and the data generated raises more questions than it answers."

With chaos still rife in testing as well as in the privatised systems for tracking contacts of positive cases, Harding is now looking ahead to the introduction of the so-called 'moonshot' saliva-based tests, which she and prime minister Boris Johnson apparently believe will give results within 15 minutes, and enable 10m tests a day by early 2021. However she has now said these tests will not be made available on the NHS, but will carry a fee

...*continued on page 2*

NHS Test and Trace: poster site ads fail to give the true picture

Also in this issue...

...continued from page 1

for individuals or companies that make use of them. Since the estimated cost of the moonshot programme is a staggering £100bn a year or more for 3.65 billion tests, this suggests a fee of at least £27 per test – at a time when unemployment is certain to be rising, the economy is in recession and a growing proportion of the population will be in severe financial distress.

Since statistics show that people living in the most deprived areas are twice as likely to die of covid-19, and are also least likely to be able to afford to quarantine if tested positive, Harding's plan is unlikely to lead to the mass roll-out of testing where it matters most.

Worse still, the moonshot tests themselves are scientifically unsound, according to a BMJ editorial which says that up to 41 per cent of positive tests are in asymptomatic people, but a positive test in those with no history of symptoms could indicate either current infection or previously resolved asymptomatic infection.

Keeping it private

On current form the testing is likely to be contracted out to private companies, possibly including those which have already been selling "sub-optimal products, possibly encouraged by the magnitude of government contracts, low levels of government scrutiny, and the lack of an effective regulatory process for diagnostic tests", as the BMJ suggests.

Even if the reliability of the test was increased to 99 per cent, the BMJ authors warn that "proposals to do 10m tests a day will generate many thousands of false positive results, causing unnecessary but legally enforced isolation of both cases and contacts, with potentially damaging consequences for the UK economy and for civil liberties."

Add to that the fact that even as ministers commit to the project, the technology does not yet exist, other than in computer simulations, and "no point-of-care tests approved for home use are currently available".

The moonshot project combines sky-high hopes for non-existent technology with astronomical cost. How far will it go before it crashes back to earth?

John Lister

Councillors decry Brompton 'merger'

THE ROYAL BROMPTON and Harefield (RB&HFT) is one of the more secretive NHS foundation trusts, publishing only minutes of its board meetings once a quarter, and no board papers.

It is now proposing to push through a merger of the Royal Brompton in Chelsea *(pictured above)* with Guy's and St Thomas's, which could see all of its most specialist services moved south of the Thames.

The trust argues the merger doesn't need a public consultation since it is a "corporate transaction", an argument rejected by Tory and Labour councillors in the Royal Borough of Kensington and Chelsea, who joined forces to pass three critical motions on the plan at an extraordinary meeting on 23 September.

The first motion underlined the potential market value of the Brompton's prime Chelsea sites as a key factor driving the plan, saying they were located in one of the highest value areas of London and could be worth more than £1bn if sold.

But by the time the land assets are sold off, the Brompton will no longer exist as a trust, with its services three miles away, because the merger is in fact a takeover. A trust statement to the council meeting admits that after this acquisition, as early as January 2021, it will increasingly exist in name only: "RB&HFT will cease to exist as an independent foundation trust after joining a newly restructured Guy's and St Thomas' NHS Foundation Trust. Both boards recognise the importance of the Royal Brompton name and heritage, and both trusts are committed to maintaining this as part of the naming of the new heart and lung centre."

The Brompton board claims that there has already been "public engagement". However this was 18 months ago, when the proposal was not a merger but a "partnership" arrangement. The public's comments even then noted that, "They are doing it for the money – it's valuable land."

And one predicted that, "There could be future pressure from NHS England to merge."

JL

Surgeries brace for impact of visa cuts

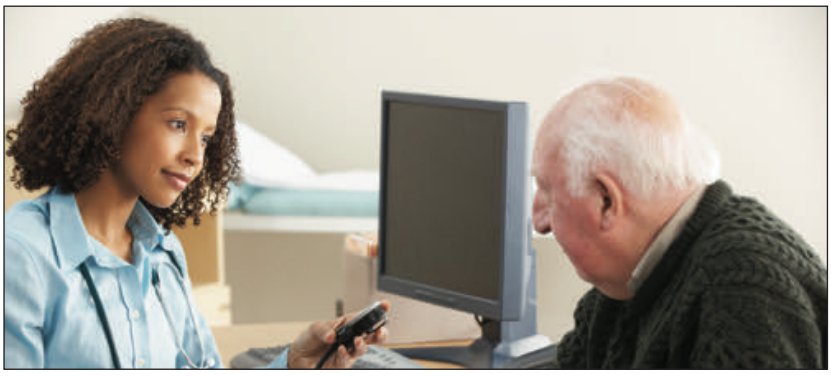
THE MOVE TO cut funding support for GP practices that employ newly qualified trainee doctors from outside the European Economic Area (EEA) – in the process potentially forcing many of those doctors to leave the UK – couldn't have come at a worse time, coinciding as it does with the beginning of the annual flu vaccination drive, largely delivered by GPs and now predicted to play a vital role in holding back the second wave of covid-19.

According to online newsletter Pulse, this support – sponsorship of licence application fees, visa certificates and immigration skills charges for the first two years for any non-EEA GP that practices employ – was curtailed in April when Health Education England (HEE) stopped reimbursing practices for these costs. It opted instead just to reimburse non-EEA GPs directly to cover their personal visa application fees.

These changes are expected to impact practices' ability to recruit and retain staff as they will increase costs. More than a third of GPs accepted onto specialty training this year will still need visa sponsorship once that training is completed.

They could also result in an exodus of medical professionals trained within the health service. NHS England's online guidance offers little reassurance on this touchy subject, coldly stating, "After completing their training, these GPs either need to return overseas, find employment with an employer that holds a tier 2 visa sponsorship licence or… apply to normalise their status as a UK resident."

"Staff absences in surgeries could hit the imminent flu vaccination drive that many hope will stop the NHS being overwhelmed this winter"



GP numbers are on the decline generally, despite a claimed 15 per cent rise in those entering training. NHS Digital's latest general practice workforce survey showed that the number of GPs overall was down by 1.8 per cent year-on-year, while the tally for fully qualified GPs (excluding registrars) had dropped by 2.3 per cent over the same period, figures described in one media report as being of "serious concern" by BMA GP committee chair Dr Richard Vautrey.

Hinting at the likely link between recruitment issues and covid-19, Vautrey added that NHS Digital's statistics were "hardly surprising when we consider the immense pressures family doctors are under… now and before the pandemic hit… before covid-19, GPs were contending with chronic underfunding, rising patient demand and toppling workloads – all of which have been exacerbated by the virus".

That link was made more urgent last week by the Royal College of GPs, which wrote to Dido Harding, head of the privately run NHS Test and Trace programme, warning that staff absences in surgeries – caused by GPs being forced to stay off work because they were unable to get tested for the virus – could hit the imminent flu vaccination drive that many hope will stop the NHS becoming overwhelmed this winter.

Reporting on the college's letter, the Guardian highlighted a recent study in the Lancet which suggested around 1,200 GPs may have contracted the virus each month during the height of the first wave of covid-19 earlier this year.

But given the income generated by GP visas – recent research by the Labour Party shows that NHS trusts across the UK have had to spend £15m on visa charges since 2017 – it's hard not to conclude that cash generation may rank as highly as the nation's health on the government's list of priorities for the NHS.

And those hoping for a speedy reversal of HEE's decision should recall the government's U-turn on the NHS immigration health surcharge for overseas health and care staff earlier this year.

A month later the Doctors Association UK found that many NHS workers were still being required to pay the charge.

Martin Shelley

Mental health demand soars after patients abandoned in lockdown

SINCE THE INTRODUCTION of lockdown measures in March, there have been concerns about the effect of the pandemic on the nation's mental health and the implications for the NHS's already over-stretched services. Now it is becoming clear just how big the challenge is and how lockdown planning left many patients high and dry.

Patients discharged

An analysis by Mind showed that 11,829 patients were discharged from mental health units in March, a sharp rise from 9,836 the previous year and up by 2,441 compared to the month before lockdown, raising concerns that vulnerable people were released into the community before they were ready.

A letter from NHS England chief executive Simon Stevens on 17 March instructed NHS hospitals to clear as many inpatient beds as they could in preparation for covid-19.

It is now clear that this blanket policy led to harm and risk for some mental health patients. Alison Cobb, specialist policy adviser at Mind said, "NHS data shows that in March mental health trusts across the country followed guidance to discharge as many people as possible to clear space for covid-19 patients, including patients detained under the Mental Health Act and those on acute wards."

Among those affected was a 59-year-old man, suffering from paranoid schizophrenia who was released from a rehabilitation unit that is part of the Central North West London NHS Foundation Trust, against the wishes of his family. He then fled to Europe. His daughter told the Guardian, "He wasn't well and has now run away… when he was released into the community they should have made sure there was sufficient provision about how they were looking after him during lockdown."

Mental health patients waiting for care were affected too. Norfolk and Suffolk Foundation Trust's decision to send letters to 300 young people discharging them from the waiting list was met with an outcry from patients and campaigners. At the time the organisation said it was a mistake, simply "a clerical error".

However, under questioning in a subsequent local council meeting the trust boss admitted that it was a deliberate decision, based on the organisation's plan for the pandemic, and prompted by worries about potential understaffing because of covid-19 illness. The trust has since apologised, with chief medical officer Dr Dan Dalton saying, "This clearly was something where we got it wrong. I'm absolutely confident it was done for the right reasons."

"The NHS Confederation report says that providers [across all mental health services] are dealing with up to a 30 per cent reduction in the number of patients they can care for at one time because of social distancing and infection control measures"

Surge in demand

In August, a report by the NHS Confederation (Preparing for the Rising Tide) found that a surge in demand for mental health services had already begun and predicted that demand will be significantly higher than pre-covid-19 levels.

A survey by the Royal College of Psychiatrists agreed, showing 43 per cent of psychiatrists have seen an increase in urgent and emergency cases following the lockdown.

The NHS Confederation report says that providers are predicting a 20 per cent increase across all mental health services, and are dealing with up to a 30 per cent reduction in the number of patients they can care for at one time because of social distancing and infection control measures.

The Centre for Mental Health has predicted that an additional 500,000 people will require support for their mental health over the next two years.

The rise in demand stems from those who were denied care during lockdown, those whose health deteriorated and new patients – flowing from the wider impacts of the pandemic, such as self-isolation and increases in substance abuse and domestic violence.

Funding anxiety

With the demand soaring there are "serious concerns" that the £2.3bn for improvements to mental health services an-

nounced in the NHS Long Term Plan in 2019 is no longer enough. In particular the funding falls short on extra costs, such as PPE, infection control, locum and more permanent staff, and ongoing costs related to new digital services.

NHS Providers, the organisation representing NHS hospitals, agrees that rising demand must be met with an urgent and full commitment from the government, saying "expansion in service provision" must be "fully and promptly funded, on a sustainable basis".

It had already noticed that demand was outstripping supply, with its first survey of trust leaders since the start of the pandemic showing 61 per cent increased demand for urgent or crisis care.

Some extra money has become available through a £10m fund announced by NHS England in mid-September, but that money is only for community initiatives, in particular those aimed at suicide prevention. With around £8m of that funding earmarked to bolster suicide prevention initiatives across 30 local areas during the 2020/21, the remainder is to be allocated to provide bereavement support for people after a relative or friend's suicide.

Same storm, different boat

Our collective mental health has deteriorated by around 8 per cent as result of the pandemic according to IFS research. More than two-thirds of adults in the UK report feeling worried about the effect covid-19 is having on their life, but the impact will not be felt evenly across society.

The Centre for Mental Health concluded that people with existing mental health difficulties and risk factors for poor mental health are likely to be affected disproportionately.

Those with historically poorer access to mental health services are the most at risk. And the well-known determinants of inequality will become more influential as the economy worsens.

Children from the poorest 20 per cent of households are already four times more likely to have a serious mental health issue by the age of 11 than those from the wealthiest 20 per cent.

People who rent houses are more affected by financial anxiety and those on housing benefit are twice as likely to have mental health problems.

We know too that members of the BAME community are at greater risk from covid-19.

Survey data shows that 42 per cent of LGBT people would like to access mental health support during the pandemic, but 34 per cent had medical appointments cancelled by providers.

Structural inequality, and differences in vulnerability to the virus and in access to services all demand a better strategic response from our local and national leaders.

The Centre for Mental Health, backed by a group of mental health charities, says, "Plans for recovery must be made with mental health equality in mind. Government must prioritise race equality and support trauma-informed approaches for all people whose lives have been affected by covid-19. Plans to modernise mental health legislation and invest in community support should be resumed and renewed at the earliest opportunity."

It calls for action to ensure people with mental health problems get access to food and medicine and that financial safety-nets are available for those at greatest risk from the virus. In the longer term it calls for steps to prevent homelessness and to improve the benefits system.

Digital answers

Providers are looking to digital services, used widely during lockdown, to continue to help manage demand. However, the NHS Confederation warns that digital services are not appropriate for all patients, adding that patient experience must play an "integral role" when the sector is looking at which transformations to maintain post-pandemic.

Indeed, a YouGov poll published this week, commissioned by NHS Property Services, the government-owned company that owns a large proportion of primary care estate, found that 38 per cent of people asked wanted face to face access to mental health and counselling services in their GP surgery or local healthcare clinic. And in the age group 18-34, often considered to be those most digitally-able, almost half cited these as a key addition to their local healthcare facility.

Sylvia Davidson and Paul Evans

Crunch time for CCG merger bids

THE LAST DAY OF September is the deadline for applications to merge clinical commissioning groups – essentially groups of general practices – into much larger bodies from next April, as required by NHS England (NHSE).

The current system

Way back before Covid, in January 2019, NHSE's Long Term Plan charted a course towards a further reorganisation of the NHS, unpicking some of the fragmentation inflicted by Andrew Lansley's disastrous 2012 Health and Social Care Act, but at the expense of reduced accountability and increased reliance on private consultancies and companies.

The transition from more than 180 CCGs to 42 'Integrated Care Systems' (ICSs) involves a complex combination of CCG mergers and legislation to lend retrospective legitimacy to the ICSs that NHSE had begun setting up in the aftermath of its 'Sustainability and Transformation Plans' in 2016.

At present the ICSs stand outside the law, with no authority to decide policy or enforce financial discipline. And despite a vague commitment in December's Conservative Party manifesto and in the notes to the Queen's Speech, there has been no sign so far of the draft legislation to change this status.

CCGs are still statutory public organisations, and their governing bodies are required to meet in public and publish board papers. They are also required to consult local communities on major changes, and can be held to account by local authority 'health oversight and scrutiny committees', which retain powers to block controversial changes and refer them to the Secretary of State for review. None of this is true of ICSs.

In a bid to escape from this level of accountability, the Long Term Plan laid down the principle that there should "typically" be only one CCG for each ICS, and the pressure was on to steamroller through mergers of CCGs across large populations and geographical areas, destroying the flimsy pretence of any genuine local links or accountability to local communities.

With an apparent government commitment to legislate to dismantle some of the Lansley Act and give powers to ICS bodies, NHSE began early last year to crank up the pressure for mergers of CCGs in readiness for a new system that seemed almost certain to end up with the CCGs becoming

redundant additional layers of bureaucracy, and facing the axe.

NHSE's pressure paid off in some areas: this April saw a massive wave of mergers that reduced 76 CCGs to just 18, compared with just two mergers involving six CCGs in 2019.

Encountering resistance

However, in many areas there was strong resistance to the pressure to merge – in many cases driven by local government, but in Staffordshire GPs led the resistance, voting by a massive 107 practices to 24 against the merger of the county's six CCGs, with a majority of GPs in only one CCG voting in favour.

There was also resistance in areas that had forged ahead and proclaimed themselves ICSs, even though they were far from integrated and the law meant they were not really systems.

In South Yorkshire and Bassetlaw, which notionally launched an ICS in October 2018, all five CCGs clung on to their status for fear their area might be disadvantaged and, having gone through the process laid down by NHSE, reported to it that they had decided merger was not the way forward for their population. As a result, that ICS exists pretty much in name only, with the CCGs making all decisions and controlling finance.

In Bedfordshire, Luton and Milton Keynes, another early implementer of 'integrated care', the ICS Partnership Board in July heard from three of the four councils in its patch. Milton Keynes, Bedford and Central Bedfordshire all made clear their continuing opposition to merging into a single CCG.

The councils were variously concerned that there was no detail as to what would be commissioned at scale, local authority and local/parish level, that the restructure was at the expense of health outcomes, and that the proposals required more consultation.

In the giant ICS 'footprint' of West Yorkshire and Harrogate, where again there has been resistance to merging into a single CCG that would be accountable to nobody, North Kirklees and Greater Huddersfield CCGs held a summer event to inform their publics that the opposition of GPs in both areas was the reason they were unwilling to merge.

Local accountability?

In the north west of England, NHSE has intervened to block moves to merge four north Merseyside CCGs into one, following the merger of Cheshire CCGs in April. Instead it has ordered that all the remaining Cheshire and Merseyside CCGs must merge into one joint CCG, covering a large ramshackle area and 2.7m people, to form the basis for an ICS. There is no appeal against an NHSE veto on the more limited merger proposal, but it's clear that CCG chiefs as well as councillors are concerned at the massive erosion of local accountability

In north-west London, attempts last year to push through a merger of eight CCGs into one were eventually postponed in the face of determined opposition led by Hammersmith & Fulham Council and local campaigners. After the plan was revived, with a consultation run mainly through the holiday period of August this year, Hammersmith & Fulham once again rejected the arguments put forward for the merger in a letter from its chief executive which notes, "A basic element of any consultation must be to make the case why the proposed arrangement would be better than the existing one. However, the proposal does not attempt this justification.

"Economies of scale are claimed but not costed. There is a singular lack of evidence in terms of patient outcomes (which are what matter most) for why a single CCG serving 2.2m people would be better than having eight CCGs now."

One final push

In north-east London, where health bosses are also trying again to push through a merger of seven CCGs (City & Hackney, Waltham Forest, Tower Hamlets, Redbridge, Newham, Barking & Dagenham and Havering), the 'managing director' of City & Hackney CCG has left it to the evening of 30 September – the final day for submission of applications for merger – to explain to Hackney Healthwatch what the proposed changes will mean.

The notice of the meeting claimed that "the public are sought as key partners in this work" – despite them having been kept deliberately in the dark, not least on the fact that the plan is now for an "Integrated Care Partnership" – rather than the ICS that had earlier been proposed.

However, it's clear that the process of forcing through more CCG mergers is not as simple as NHSE might have imagined, and the next step – from merger to creating ICSs that are any more than an empty phrase – is likely to be even harder.

Meanwhile in south-west London, where six CCGs tamely merged in April, opposition is growing to the plans to build a new, but much smaller acute hospital on the old Sutton Hospital site, alongside the downsizing and downgrading of the existing hospitals at Epsom and St Helier, bringing a near-halving of the numbers of acute beds. Croydon council has now joined with Merton in referring the £400m plan to the Secretary of State for review – leaving the LibDem-led Sutton council sitting on the fence.

John Lister

The next Lowdown will follow up our round-up in June and further update the progress on establishing ICSs, and the extent to which this is accompanied by a huge expansion of private sector consultancy and involvement.

Why people oppose CCG mergers

THE MERGER OF clinical commissioning groups (CCGs) has been contested locally in many areas, primarily because the loss of more local CCGs further limits the extent to which NHS management can be held accountable or pressed to respond to the health needs of specific communities.

Critics argue that the strategic objective of creating Integrated Care Systems (ICSs) also brings with it the threat of remote, unaccountable bodies, each tied to rigid cash limits ("control totals") and led not by local needs but by private management consultants.

Merged CCGs covering vast geographical areas – and in some cases in excess of 2m population – are unlikely to be more responsive to local pressure. Eliminating CCGs also cuts the links with many local council's scrutiny committees.

Plan delayed, then...

The NHS England (NHSE) Long Term Plan, which demanded the mergers, was sidelined for four months this year by the covid-19 pandemic. On 17 March, before the lockdown, NHSE chief executive Simon Stevens spelled out a series of new priority actions to be implemented by every NHS foundation trust and CCG, and declared that NHSE was, "deferring publication of the NHS Long Term Plan Implementation Framework to the autumn, and recommending you do the same for your local plans".

However that deferral came to an abrupt halt on 31 July with a letter from Stevens and NHS chief operating officer Amanda Pritchard headed 'Important – for action – Third Phase of NHS response to covid-19'.

The letter gave trusts just the month of August to draw up and implement delivery plans, to run from 1 September, to "restore full operation of cancer services" and rapidly resume normal levels of service for elective care.

But the letter also made clear that while working flat out to get services back up and running, NHS bosses in some areas that had not already done so were also expected to force through CCG mergers to create the basis for ICSs.

Streamlined approach

In the letter Pritchard says, "As we move towards comprehensive ICS coverage by April 2021, all ICSs and STPs should embed and accelerate this joint working through a development plan, agreed with their NHSE/I regional director, that includes … plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system. Formal written applications to merge CCGs on 1 April 2021 needed to give effect to this expectation should be submitted by 30 September."

This has not gone down well in many areas, where councillors and campaigners have agreed that no clear case has been put forward showing any advantages of merging into larger, more distant organisations.

Indeed, the positive examples of what merged CCGs (and ICSs) could achieve are all a confirmation that the NHS could already be working better – if it were not for the fragmentation and bureaucracy imposed by Andrew Lansley's 2012 Health & Social Care Act.

On 18 Sept the online news site HSJ reported NHSE's intervention to reject plans for two merged CCGs rather than one to span Cheshire and Merseyside, and said, "Other large systems such as North East and Cumbria, Greater Manchester and South Yorkshire and Bassetlaw have also been looking to retain more than one CCG. … It is unclear what would happen if the move for a single CCG is heavily opposed by practices and councils."

Consultation a legal requirement

Indeed, guidance on mergers from independent CCG membership organisation NHS Clinical Commissioners and the Local Government Association makes clear that, "What this looks like in each local area may vary, with some areas having more than one CCG per ICS, while others will include more than one local authority."

It also notes that, "Engagement between CCGs and local government is not just important, it is also a legal requirement. All CCGs that are applying to merge must show that they have effectively consulted with the relevant local authority [or authorities] regarding the proposed merger and have a record of the feedback they receive."

The legislation and regulations covering CCG mergers (which requires dissolution of the merging bodies) also suggest:
– there must be an assessment of the likely impact of the dissolution on the persons for whom the CCG to be dissolved has responsibility
– each dissolving CCG must also "seek and take into account the views of unitary local authorities, other CCGs affected by the dissolution, and individuals to whom any relevant health services are being or may be provided"

Who will now blink first in the stand-off: local authorities or NHS England?

John Lister

Contract award process needs more scrutiny

IN A CRISIS we need quick thinking and resourcefulness – no time to explain decisions. That's the justification for the government bypassing scrutiny and transparency, but revelations about dubious deals with unqualified companies and political cronies stoke cries for better governance and more democracy.

The latest in a succession of pandemic purchasing failures reveals how two hand-sanitiser contracts for £8.4m were signed on behalf of the Department of Health & Social Care with a dormant company with only one director.

Further contracts were signed with separate Chinese firms for antibody tests that didn't work and 50m face masks were purchased that had the wrong ear loops, so they couldn't be used.

A staggering £15bn worth of contracts were signed in a belated bid to source personal protective equipment (PPE), but three of the biggest winners were unlikely companies specialising in pest control and confectionery wholesaling, along with a private fund owned through a tax haven.

Not so rubust

Contracts to deliver mass covid-19 testing were awarded predominantly to private companies, in a new centralised system, by-passing the option of expanding the existing public laboratory network, and is now struggling to keep up.

Serco was awarded a £45m test-and-trace contract despite incurring fines for failures on another government contract just a month before.

And were you surprised to read this Sunday Times story? "Contracts for personal protective equipment (PPE) worth more than £180m have been awarded to companies owned or run by prominent supporters of the Conservative Party."

A government spokesman insisted, "There is a robust process in place to ensure orders are of high quality and meet strict safety standards, with the necessary due diligence undertaken on all Government contracts."

With at least £1.7bn in deals with the private sector having so far been signed, but with many hidden from public view, nobody can yet be sure of the overall total and how much of this money was spent.

Why aren't there more controls? Because in "exceptional circumstances" the procurement rules can be set aside, and firms awarded contracts without a competitive bidding process, all confirmed in a Cabinet Office published note, but sagely it suggests keeping proper notes of decisions, to help with future legal challenges.

Behind closed doors

In this situation the government pledged to publish the details of contracts, including 600 for PPE. It has repeatedly failed to do so, leading a crossparty group of MPs, backed by the Good Law Project, to take legal action.

During the pandemic the government can carry on using the exemptions in competition law for unusual circumstances, only, it seems, releasing information under public pressure, but the bigger question is do these procurement rules ever protect the public interest?

Even in more normal times public information about government procurement is poor. For scrutiny the public must rely upon an audit trail once money has already been spent, often by the Public Accounts Committee or the National Audit Office.

Despite good intentions the public interest is predictably under-represented during the procurement process. Signed contracts are hidden behind commercial confidentiality. The doctrine underpinning current competition law is that public interests are best served through the workings of competitive markets.

It seems public influence, over the local decisions of their clinical commissioning group (CCG) and NHS foundation trusts – who spend billions outsourcing on their behalf, is low and declining. Under the radar the NHS is being reorganised, CCGs merged over wider geographic areas, making decisions more remote from the public they serve.

Covid-19 arrived just as NHS England was trying to steer a new course away from competition towards integration, but it won't mean less outsourcing. No law changes as yet, but when it happens how will the system provide the "robust" public interest decision-making that our leaders think is already in place?

Paul Evans

NHS performance recovering, but record numbers are waiting

THE LATEST performance figures show that the covid-19 disruption of the NHS continued through July, with a record 2.15m patients waiting more than 18 weeks to start hospital treatment – that's triple the figure for July 2019. However, the new figures also show that services have rebounded from the extremely low levels of activity seen from March to June.

The total number of people admitted for routine treatment in hospitals in England was down by about 50 per cent in July compared with a year ago, but this fall is not as steep as earlier in the pandemic. In June the year-on-year decrease was 67 per cent, and in May 82 per cent.

In July, around 140,000 operations such as knee and hip replacements were carried out, up from just 41,000 in April. In March virtually all routine operations were stopped as staff and resources were directed to patients with covid-19.

NHS England medical director Professor Stephen Powis described it as a "substantial rebound in routine appointments and operations, which have more than doubled since the peak of Covid".

Encouraging signs

There are some encouraging signs of work increasing in other areas: 21,600 cancer patients began their treatment in July, up from 16,600 in May, although still down from 28,000 in July last year. And A&E is getting busier, with 1.7m visits in August, up from 916,000 in April, though still down 19 per cent from August 2019.

Urgent cancer referrals made by GPs were at 179,503 in July 2020, down 19 per cent from 221,805 a year earlier. However, this fall is lower than previous months – a year-on-year drop of 21 per cent in June and 47 per cent in May.

Powis said that "pleasingly, cancer radiotherapy treatments are now fully back to their pre-Covid levels". There is still, however, a big issue with diagnostic tests, with the figures showing that just under 500,000 patients in England had been waiting more than six weeks for a key diagnostic test in July. Last year the equivalent number waiting longer than six weeks was 37,206.

The number of patients having to wait longer than a year continues to grow. July saw it at its highest level for more than a decade, with 83,203 waiting more than that length of time – the highest number for any month since November 2008.

NHS Providers deputy chief executive Saffron Cordery said, "Today's figures show just how hard trusts and frontline staff are working to restore services for non COVID-19 patients."

She added that staff are also working under various constraints, including "a reduction in available diagnostic testing equipment and ambulance capacity due to the need for deeper and more frequent cleaning between patient treatments, and additional time needed to wear and change personal protective equipment".

King's Fund senior analyst Gbemi Babalolaat also noted that, "NHS staff are working hard to restore services to full capacity, and help is available when people need urgent care and treatment."

Challenges ahead

However, commentators have noted that we are heading into the winter months, the most challenging part of the year, and Babalola called for honesty about what can be achieved in these months, predicting that long waits for routine diagnostic and surgical procedures are likely to be "here to stay".

Society for Acute Medicine president Dr Susan Crossland "implored" the government to publish full winter crisis planning proposals which include investment into staffing and estates to cope. Citing the reduction in acute beds as a major concern, she added, "We cannot allow corridor care to return and, therefore, again urge a focus on the advantages of same-day emergency care to allow rapid assessment and treatment of patients without needing admission."

Sylvia Davidson

Number of diagnostic tests still down year-on-year

NHS staff make direct appeal to PM on pay

A PAY CLAIM submitted by the trade union Unison would see every NHS employee receive £2,000 or more by the end of this year. The union – which represents staff across the NHS including healthcare assistants, radiographers, porters, midwives and paramedics – says the rise is worth around £1 an hour. If the claim is accepted, minimum wages in the health service would go above £20,000pa for the first time, according to the union.

Over the past summer a series of public rallies have taken place across the country in support of health workers. And this week Unison members delivered their own appeal to the PM:

"Health staff have heard how much your recent personal experiences taught you about the value of what they do. They are now looking for you to reflect that in their pay. So, Prime Minister, why wait?"

A survey of the public showed substantial support, with two-thirds of those questioned by Com Res agreeing that the increase should be significant in the light of the covid-19 pandemic. Unison head of health Sara Gorton said, "There's a tough winter ahead and a pandemic that shows little sign of disappearing. Giving health staff a morale boost now is much-needed ahead of any good news about a vaccine."

With 100,000 members in the health service, trade union Unite also demanded that pay discussions between the government, the NHS and health unions start without delay. It called for staff to receive an early pay rise of 15 per cent or £3,000, whichever is greater.

Unite national officer for health Colenzo Jarrett-Thorpe said, "Hundreds of health and social care staff have lost their lives in the continuing battle against covid-19, which has heightened the deep appreciation that the public has for the NHS."

Paul Evans

'Phone ahead' A&E winter plan

ANOTHER MAJOR round of efforts to divert patients away from A&E departments is under way as winter approaches.

Walk-in patients are to be told by selected hospitals to phone ahead and book appointments in emergency departments, while hospital bosses are pressuring 111 call handlers to be less "risk averse" – and divert more than the current 18 per cent of calls to alternative services rather than to A&E.

Online news site HSJ reports at least one major hospital in every "health system" is expected to trial the new arrangements, although the problems of ensuring that walk-in patients are aware in advance of the need to phone ahead – and able to do so, especially patients on low incomes and those with mental health needs – appear not to have been discussed.

Nor is it clear where patients should be sent instead, especially when there have also been complaints by GPs and the NHS Confederation that some callers have been wrongly directed by 111 to primary care during the covid-19 pandemic, delaying their access to appropriate treatment.

The 111 service replaced NHS Direct in 2014, and in some areas it has since been outsourced to different providers, and has been hit hard by a decade of NHS underfunding and privatisation. Operators can earn as little as £9 an hour and receive as little as six weeks of training.

There are concerns that an inadequately prepared and funded 111 system failed unknown numbers of patients when swamped with calls in the early stages of the covid-19 crisis.

Royal College of Emergency Medicine policy vice-president Adrian Boyle told HSJ, "NHS 111 is only as good as the services that are behind it." Concerns over local 111 services reflect "a lack of alternatives to the emergency department. … there really [are no] adequate community alternatives to [A&E] care."

John Lister

To help secure the future of our NHS through campaigning journalism, please support us

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 – we track contracts and collect evidence about failures of private companies running NHS services

First we must escape the covid-19 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 to account 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 virus, we are now asking those who can to give as much as you can afford.

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

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 posted 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, please email us at contactus@lowdownnhs.info