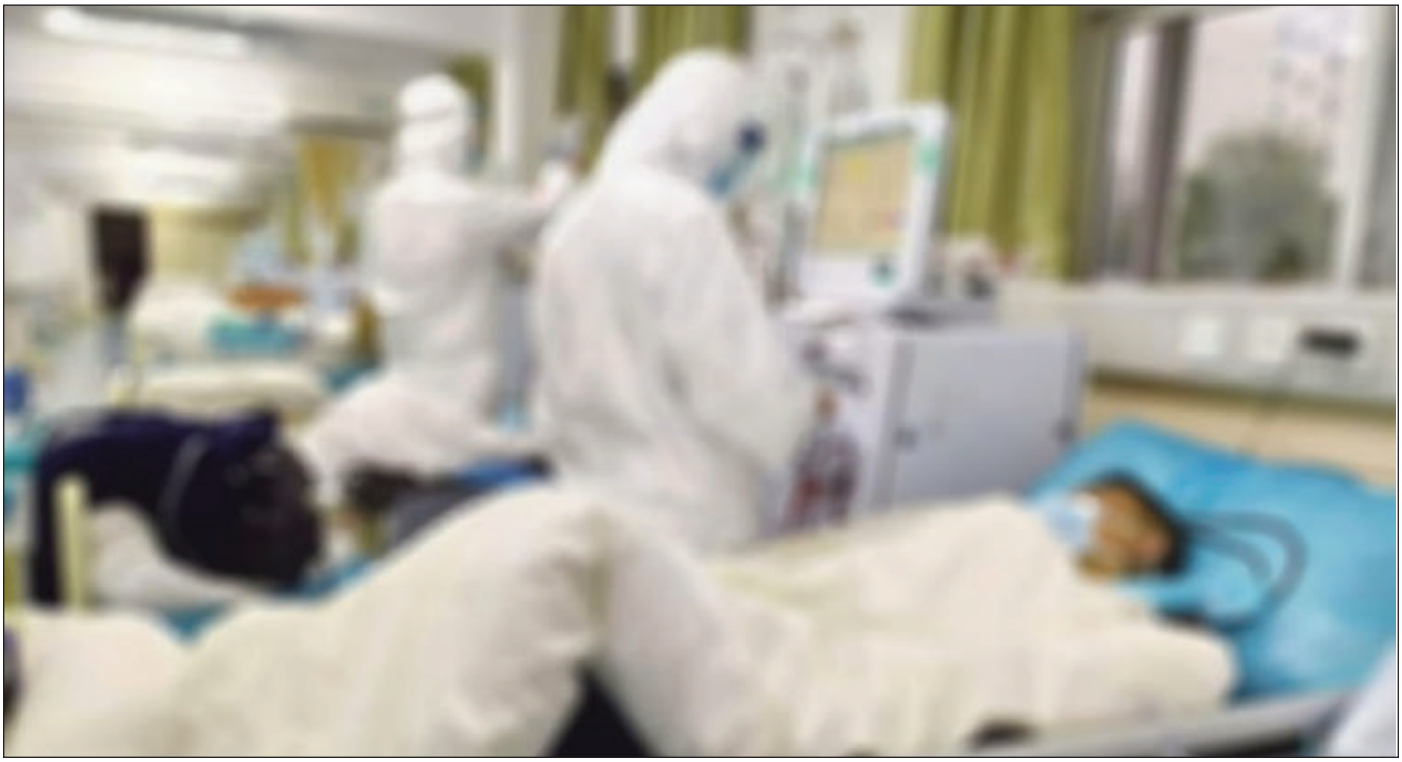
The lowdown

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

People's Covid inquiry finds "dismal failure" to save lives



The report into the handling of the coronavirus pandemic was published on Wednesday 1 December, two years on from the emergence of the novel virus and COVID-19, the deadly disease that has killed over 5.2 million people – 167,000 of them in Britain. Keep Our NHS Public organised the inquiry which has filled the deafening silence from Government.

The Prime Minister had steadfastly refused to organise an inquiry even when it was obvious to all that a rapid-learning inquiry was needed to save lives and halt the tragic repetition of government mistakes and misjudgements.

In the absence of a formal public inquiry into the pandemic, The People's Covid Inquiry began in February 2021 and concluded its hearings in the summer.

The purpose was in the title: 'Learn lessons – save lives'.

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It covered all aspects of the Government's handling of the pandemic and heard testimony from a wide range of individuals and organisations.

These included previous government advisors and key academics, as well as frontline workers and bereaved family members.

The Inquiry was chaired by world renowned human rights barrister Michael Mansfield QC who, together with a panel of experts, has now delivered their findings and recommendations on all main aspects of the pandemic to date:

"This Inquiry performed a much-needed and urgent public service when the nation was hit by a catastrophic pandemic coincident with an unprecedented period of democratic deficiency.

"It afforded an opportunity for the beleaguered citizen to be heard; for the victims to be addressed; for the frontline workers to be recognised; and for independent experts to be respected.

"When it mattered most and when lives could have been saved, the various postures adopted by government could not sustain scrutiny."

The findings are damning – the recommendations are urgent and potentially life-saving. But the reasons behind why the 6th richest nation in the world, with a proud NHS and public health reputation, has the 27th worst death rate of 190 nations and the worst economic impact of the OECD countries are shocking.

The joint Health & Social Care and Science & Technology Commons Select Committees' report in October this year declared the handling of coronavirus to be the worst public health failure.

Our report exposes the failings of the UK response to be the worst political failure. There is a case to answer of gross negligence and misconduct in public office.

In his damning assessment of the Government's pandemic handling, Michael Mansfield argued the case for the charge of 'misconduct in a public office' by government ministers:

"This People's Covid Inquiry report is unequivocal – [there has been a] dismal failure in the face of manifestly obvious risks … It was plain to …[the organisers of the Inquiry] that Government words were bloated hot air, hoping to delay and obfuscate. Within this narrative lies a theme of behaviour amounting to gross negligence by the Government, whether examined singularly or collectively. There were lives lost and lives devastated, which was foreseeable and preventable. From lack of preparation and coherent policy, unconscionable delay, through to preferred and wasteful procurement, to ministers themselves breaking the rules, the misconduct is earth-shattering."

Testimony

The Inquiry heard the sadness and the questions from bereaved families demanding justice.

It heard the pride of NHS, care and other frontline staff and we heard about their pain, exhaustion and their moral injury.

The Panel listened to vital expert testimony on failings in public health, on workplace safety, on the impact of inequalities, on the running down of the NHS.

There was disastrous policy and behaviour in public office at every stage.

Pre-pandemic, 10 years of austerity policy left the NHS exposed and social care in danger of collapse. Pandemic planning exercises, including Exercise Alice in 2016 based on a coronavirus pandemic, gave clear warnings which were ignored – on exactly the dangers exposed: insufficient stocks and qualities of PPE, insufficient hospital beds, ventilators and staff, a lack of capacity and data systems to test, contact trace and isolate, and to regulate borders.

Delayed response

Government responses to the pandemic spread, despite the experience of China in December -January and Italy in February-March 2020, were unforgivably delayed. The 2-3 week delay before lockdown in the UK when cases were doubling every 3-4 days caused at least 20-30,000 avoidable deaths. Two further lockdowns were delayed in the face of scientists' urging action and a tens more thousands of deaths resulted in January-March 2021.

Running through this whole time from pre-pandemic to initial response and across three lockdowns has been the refusal to accept WHO basic public health policy: 'test, test, test'; 'go hard go early'; the essential need for rigorous case finding, testing and tracing, isolation and quarantine with support for those who need it. Never has our Government put this FTTIS system in place.

The heightened inequalities of the past decade led to brutally discriminate impact on the low-paid, unemployed, women, disabled people (six in every 10 deaths) and on Black, Asian and ethnically diverse communities. People in multi-generational households, more crowded accommodation, working zero-hours and low-paid jobs all were exceptionally at risk.

We learned to redefine the meaning of 'key worker' as frontline staff across sectors went to work unprotected by

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SOS NHS – fighting to rebuild and expand NHS capacity

A powerful new link-up between Health Campaigns Together, NHS Support Federation, Keep Our NHS Public and the health unions is set to launch a major new SOS NHS campaign to challenge the 12-years of under-funding and growing staff shortages that have plunged the NHS into its deepest-ever crisis this winter.

The campaign will run into the new year, and combine online resources and social media with mobilisation at local and regional level, delivering solidarity and some hope to beleaguered front line staff battling to keep services afloat.

And, while some excellent and insightful reporting by a handful of journalists in serious newspapers and trade press has been vital to chart the developing crisis, the campaign also, aims to combat the complacency and superficiality of too much mainstream media reporting of the NHS, that has left much of the wider public unaware of the scale of the problem, and allowed ministers to repeat deceptive and misleading claims.

The objective is to trigger a much wider movement that can pile pressure on Tory MPs, especially in newly-won seats, to demand another government U-turn – to reopen and revise the inadequate recent Spending Review, which locks in effectively frozen funding until 2025, and gives no extra capital to repair and remodel hospitals to reopen lost capacity.

It's vital for campaigners, opposition parties and health unions to argue now for a plan to build a sustainable, publicly owned, run and driven NHS. It's plain for all to see that the current workforce plan, NHS Long Term Plan and the Health and Care bill all not only fail to address the harsh reality, but as the NHS weakens, push towards a larger, stronger private sector cashing in where it sees profit to be made.

Battling misinformation

Ministers keep arguing that spending is at "record levels": but it's clear to all that the NHS faces unprecedented levels of demand. Warnings on all sides stress that it lacks staff, beds and resources – as a result of ten years of frozen funding while the population has grown by 5 million.

Much larger sums of capital and revenue than the government has allocated are needed to catch back up with what has been lost since 2010 and put the NHS back on its feet.

By 2019 NHS Providers calculated that if spending had continued from 2010 at the average level it had grown from 1948 to 2010 instead of being frozen in real terms, the annual budget would have been £35 billion higher: and since then the gap has grown further.

So even if we now do have 'record spending,' it is at a level that is still nowhere enough to restore 2010 performance or meet demand – let alone tackle the cumulative problems of our increasingly dilapidated hospitals, inadequate provision and obsolescence of vital equipment for diagnostics and treatment, or build the promised 40 or 48 'new hospitals'.

The extra allocation to NHS England equates to £15.6bn spread over three years. This falls well short of the £10bn extra for 2022-3, called for by NHS Providers and the NHS Confederation.

And while Sajid Javid boasted on Twitter on October 28 that he

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was "Delighted to see record staff numbers working in the NHS - 5,500 more doctors & 10,000 more nurses," and claimed "The NHS is recruiting even more people to join their ranks to help us recover from COVID-19 & tackle the backlog," this came only three days after he had admitted that "a lot more" staff were needed.

Growing dependence on the private sector

The funding crisis underlies all aspects of the current NHS crisis, and is the major factor in the latest rounds of privatisation.

If the spending review stands unchanged, by 2025 we would be half way through a second deadly decade of declining NHS – but soaring profits for a private hospital sector. Private hospitals stand to gain, both as contractors treating NHS funded patients, and as private providers of elective care to desperate self-pay patients raiding savings or borrowing to pay for operations to avoid facing agonising waiting times for NHS care. (See box)

Indeed the scale of increased NHS dependence on private providers and contractors has been massively increased by the Covid pandemic – coupled with the lack of NHS capital to invest in its own facilities and equipment. New "community diagnostic hubs" seem certain to be achievable only in a lop-sided 'partnership' with private companies that can put up the necessary cash—and then reap a profitable slice of the action, as has already occurred in Somerset.

As we warned in The Lowdown, NHS England guidance on new imaging networks also looks to an option in which an entire network would be contracted out to a private company. During the Covid pandemic ministers have turned instinctively and without competitive tender to the private sector to establish new "Lighthouse" laboratories, and run a new mega-lab in Leamington Spa.

The common factor in each case is that the NHS lacks the capital it needs.

And of course, most dramatically of all, when money was apparently no object, ministers turned first and without any due process to the private sector -- Deloitte, Serco and Sitel, and a 'fast-tracked' list of politically connected crony firms as their initial response to the Covid-19 virus, bypassing existing public health networks to set up a new, privately-run, eye-wateringly expensive and spectacularly ineffective 'test and trace' system, and commission testing kits and PPE. Only when it came to rolling out the vaccine was the NHS brought fully in to the leading role it should have been playing all along.

Rebuild crumbling infrastructure

While money has been pumped into contracts to treat NHS patients in private hospitals, there is no capital to invest in re-modelling hospital buildings, refurbishing and where necessary rebuilding to enable the hospitals to reopen the thousands of beds that have been closed or left unoccupied since March 2020 because of social distancing and infection control. Rishi Sunak has to be told to make a fund of up to £3bn immediately available for this work to be done – and end the need to ship NHS patients off to costly and inefficient private hospitals.

But the lack of capital reaches wider: across England the bill for backlog maintenance to repair crumbling buildings and fix or replace clapped out equipment has soared to £9.2 billion – double the £4.5bn capital allocation to NHS England. The lack of maintenance causes thousands of incidents each year that interfere with clinical care and put patients at risk.

Rishi Sunak has to be told to make at least £5bn extra available, ringfenced as a fund for trusts to cover their most significant and urgent maintenance problems as soon as possible, with additional capital each year to wipe out this shameful backlog.

A dozen or so hospitals built in the 1970s using reinforced autoclaved aerated concrete planks are in serious danger of collapse. Among the hospitals affected by the crumbling concrete are Airedale in West Yorkshire, Crewe's Leighton Hospital (Mid Cheshire); Hinchingbrooke (North West Anglia FT); Wexham Park (Frimley Health FT); James Paget Hospital, Lowestoft; Queen Elizabeth Hospital, Kings Lynn, and West Suffolk Hospital (Bury St Edmunds).

West Suffolk NHS Foundation Trust is so concerned over the threat that it has hired a law firm to assess the risk of being charged with corporate manslaughter should any hospital collapse and kill patients, staff, or visitors.

Several of these hospitals are in such a dire state that it could be cheaper to knock them down and rebuild – but there is no capital to do so: just three of the schemes (Leighton, West Suffolk and King Lynn) have been costed at almost £1.7bn between them. Rishi Sunak has to be forced to make the necessary funding available as soon as plans are in place to partially or completely rebuild these hospitals that put patients and staff at risk – this could easily add up to £6bn.

And while we look at inadequate capital allocations, the £2.7bn allocated to build six, and then eight prioritised 'new hospitals' was completely unrealistic to begin with, but is even less plausible now that the New Hospitals Programme insists the same pathetic pot of cash has to stretch to cover costs of eight previously existing schemes – including two long-delayed PFI hospitals held up by the 2018 collapse of Carillion, the Royal Liverpool, now due to open next year, and the Midland Metropolitan in Smethwick, not now due till 2023.

The New Hospitals Programme itself, which during the summer instructed all of the priority schemes to submit new plans costing no more than £400m – implying drastic cutbacks from the

schemes already drawn up – has now been dropped to a "red rating" by the government's infrastructure watchdog the Infrastructure and Projects Authority, which defines this as meaning:

"Successful delivery of the project appears to be unachievable. There are major issues with project definition, schedule, budget, quality and/or benefits delivery, which at this stage do not appear to be manageable or resolvable."

It's all but certain that a central issue in this unfavourable rating is the lack of capital to complete the new hospitals which were central to Boris Johnson's 2019 election manifesto and campaign: estimates at the time suggested the full cost could be as high as £24 billion, and not less than £18bn: Rishi Sunak needs to be told to make this money available as soon as clinically viable plans have received planning approval and the go-ahead from the NHS.

Meanwhile, as The Lowdown has reported, the government has invited trusts to bid to be one of eight additional hospital projects to be funded, bringing the total schemes to 48 – but so far has allocated no additional capital to make the effort worthwhile. A clutch of schemes have been published, adding up to a total cost between £3.4bn and £5.1bn.

There is also need for NHS capital to build its own community diagnostic hubs and its own elective surgical hubs to streamline efforts to reduce the waiting list. And capital and revenue funding are also needed for investment in mental health services, which have been promised more staff and parity of esteem for years on end with no extra resources to match.

Adding all these capital schemes together suggests a need for an extra £10-12bn immediately, and at least another £28bn in the next few years as plans to replace collapsing hospitals and for the 48 'new hospitals' get the go-ahead.

Further investment is also needed at local level to rebuild public health services that have been foolishly cut back and are now straining to support the fight against Covid, but should be a mainstay of the fight to tackle health inequalities and reduce the pressures on the NHS.

Responding to the staffing crisis

NHS capacity of course is much more than buildings and beds: staff shortages are a major threat to safe services and an obstacle to restoring the capacity lost during the pandemic.

As an immediate step it is vital to ensure that all constraints of spending on agency and bank staff are lifted now, to ensure trusts have the scope to bring in temporary staff wherever they are available and needed to keep services going this winter, when again England's NHS will be struggling to cope with thousands of Covid patients (6,280 at November 23) as well as record numbers of emergency patients, and a near-6 million backlog of waiting list patients – with thousands of NHS beds still out of use since the pandemic struck in early 2020.

Delivering on government promises to recruit more nurses, mental health professionals and GPs requires more revenue funding almost immediately, to ensure ring-fenced resources are put in place to expand recruitment and training of new professionals.

The ridiculous decision of Tory MPs to vote down Jeremy Hunt's proposal for two-yearly reviews of staffing levels and workforce plans serves only to underline the yawning gap where there should be a workforce strategy, and the lack of realism in ministers' attempts to hold down NHS pay.

A substantial across the board pay increase for all NHS staff is also needed – over and above the 3% 'increase' that has already been swallowed by inflation and increased national insurance payments – to show hard-pressed and demoralised staff who are beginning to leave that they are valued, help retain them – and make it more attractive for qualified staff who have left already to come back and work for the NHS.

A combination of investment to make it possible for skilled staff to do their jobs safely and well and investment in their pay and conditions maximise the chances of building and retaining the staffing levels the NHS needs to rebuild capacity.

With pay in some supermarkets and service industries now outstripping the NHS, this combined investment in staff, a zero tolerance crackdown on bullying and harassment, all forms of discrimination and an investment in staff welfare and wellbeing are also necessary to make the NHS an employer of choice.

And to tackle the dwindling recruitment of EU and other overseas qualified staff to strengthen NHS and social care teams the government has to scrap all limits on overseas recruitment and the counterproductive migrant surcharge and visa fees which spell out a message that foreigners are no longer welcome. The cost of these measures in lost revenue would be minimal and the potential benefits very substantial.

While the extra spending required is substantial, it will, as health spending always does, generate other benefits including the creation of more jobs in construction, in health care, and the supporting industries, which in turn will generate economic growth across the country.

Above all the NHS needs a realistic workforce plan, based on the projections of future health needs.

Sajid Javid's highly politicised attempt to make political capital out of launching a new "NHS Reserves" scheme, branded with the Tory Party logo, indicates that ministers are still refusing to take this issue seriously, and intent on propping up their own position rather than supporting the NHS.

Any genuine effort to "mobilise a broad range of fully trained staff, from retired doctors to IT experts", as NHS Reserves claims

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to do, must be combined with the measures outlined above to ensure that the NHS is able to convince any returning staff that it offers significantly better terms and conditions than the ones so many have left in anger and frustration.

Futures intertwined

It's also important to note that all of these necessary investments in the NHS will still fail to deliver the most efficient service without the long-needed root and branch reform of the dysfunctional, largely privatised social care system which suffered so heavily during the peak of Covid, and which is now struggling in many areas to deliver home care support or care home places.

The chaos that is social care needs to be replaced by a new national care and support service that is owned and run by for the needs of the clients, not the profits of private businesses.

The lack of such a service means thousands more acute hospital beds are filled with patients who should be discharged to support outside hospital, but who can't be because no such support exists.

The Health and Care act proposal to strip away the legal right even to have patients' needs assessed before they are discharged risks making this even worse.

More than money is required to tackle this crisis, not least tough regulation and scrutiny to ensure any increased funding for 'social care' goes towards improved services, pay, conditions and staffing levels rather than straight into off-shore bank accounts of the multi-national corporations running many care homes.*(See page 7 for more on the growing crisis in adult social care.)*

John Lister

Private hospital's income from the NHS:

The staggering £2.15 billion paid out by the NHS to private hospitals since the Covid pandemic, to cover their costs and ensure capacity would be available, have been broken down by Private Eye (issue 1561).

It found £468m (boosting its revenue by more than 50%) had been paid to the largest hospital chain Circle Health Holdings, with 54 hospitals and over 2500 beds, which has now been acquired by grasping US health corporation Centene. The NHS payments effectively trebled the value of the company.

£430m was paid out to Spire, with 39 hospitals and 1,870 beds, helping to almost double the company's share price.

And Australian-owned Ramsay Health Care UK picked up a cool £385m (equivalent to 76% of its revenue) in the first 13 months of the pandemic for providing capacity in its 29 hospitals with 892 beds.

Both Spire and Ramsay have bragged that the increased NHS waiting list offers them even more lucrative possibilities with self-pay patients. Spire's 2020 Report notes that they were able to keep back beds from the NHS deal to ensure they could continue to treat private patients, and that some of this was exceptionally profitable: "Q4 saw exceptionally strong growth in self-pay revenue with priority given to more clinically urgent complex cases, which carry a greater average revenue per case."

Spire's Strategic Report notes: "our self-pay admissions were broadly in line with the same period in 2019. This wave of activity, following the pause between March and August, was largely due to pent up demand and a desire by people to avoid a lengthy wait for treatment in the NHS at a time of increasing NHS waiting lists and times."

NHS England's eagerness to strengthen its ties with Ramsay was underlined in October when NHS England's Director of Clinical Improvement turned up to cut the ceremonial ribbon, opening a new Ramsay Hospital in Chorley – where the future of NHS acute services remains uncertain.

The private hospitals have obviously been happy to accept NHS subsidies to cover their costs during the Covid lockdown, and to fill their otherwise under-used beds with NHS patients as part of the 4-year £10bn "framework" deal announced last autumn.

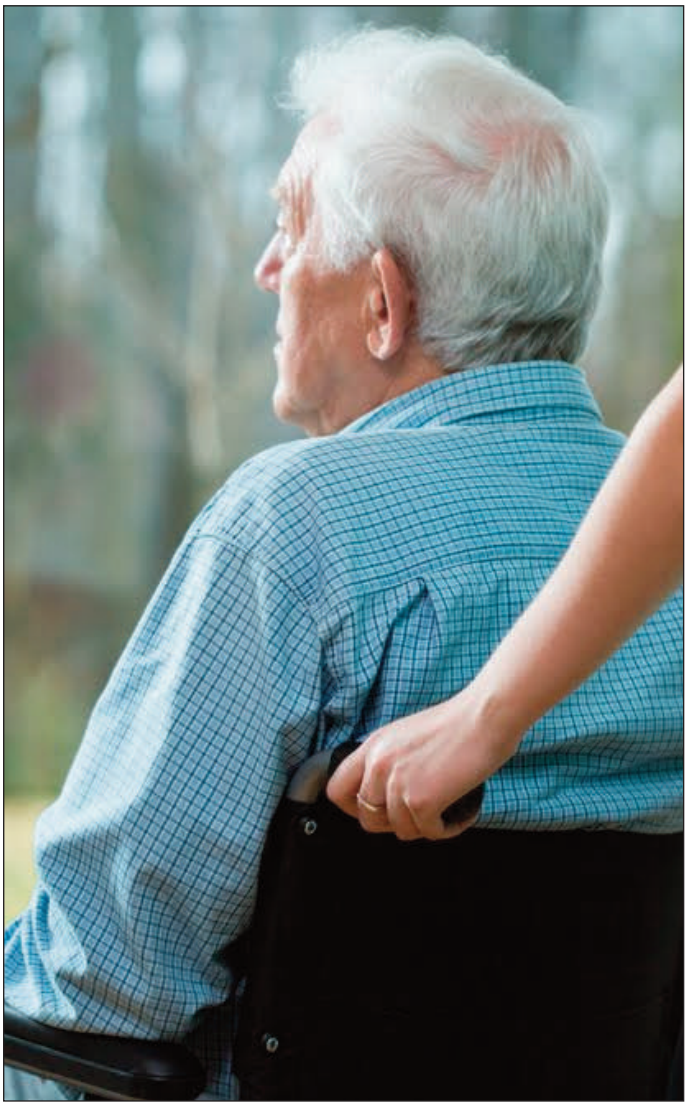
But it's clear that, despite the lavish payments, nowhere near the full 8,000 private sector acute beds have been made available to the NHS, and fewer still have been used. If they can choose, the hospitals themselves would clearly rather treat more profitable self-pay and privately insured patients than fill beds with NHS patients at the lower NHS tariff cost.

But even utilising all of the private acute beds would still leave the NHS still facing a drastic loss of capacity compared with 2019 at the end of the four years, and leave the capacity gap unresolved, with the NHS more chronically dependent on the private sector.

As private hospitals increase their caseload, they poach more staff from the same limited pool of NHS-trained staff – increasing the pressures on front-line NHS services – with NHS teams split up and vital staff redirected to work away from main sites in small private hospitals.

Any benefit in access to additional beds for elective work would be offset by the greater problems maintaining adequate staffing of emergency services. Private hospitals' gain is inevitably at the expense of the NHS.

Adult social care – kicking the can down the road again



The long-awaited White Paper on adult social care unveiled in the House of Commons this week proved to be a damp squib, little more than a 100-page 'holding' statement of intent or stopgap measure while the government worked on the more awkward question of health and social care integration – the latter now the focus of a follow-up paper with no release date known as yet.

The policies talked up by care minister Gillian Keegan do little more than rehash and re-present various elements of the new Health and Care Bill and its 'build back better' plan for a "once in a generation" transformation of adult social care, the latter unveiled by the government only last week and which introduced a cap on social care costs, a mere seven years after the enabling legislation made its way onto the statute books.

And just like the care cap legislation – now heading off to the Lords for further consideration, despite the tabling of a controversial amendment in the Commons last week which undermined its vote-winning 'halo' potential – the adult social care paper (snappily titled 'People at the Heart of Care') was greeted with little enthusiasm by leading stakeholders.

The Association of Directors of Adult Social Services (ADASS), Carers UK and the National Care Forum were lukewarm in their responses, and even Jeremy Hunt, the chair of the Commons health and social care select committee, attacked the paper, calling it "three steps forward and two steps back", and saying it would do nothing to ease pressures on hospital wards or help older people get the care they need.

So, with some providers already refusing to deliver new care packages because of staff shortages – leaving hospital managers unable to discharge patients – and with assessment waiting lists building up and home closures continuing at an alarming rate, it's clear that far greater support for the adult social care sector is still desperately needed.

A sector in crisis

Just this week, for example, ADASS published the results of a snap survey, undertaken last month, showing that:

– almost 400,000 people are now waiting for an assessment of their needs or for service provision

– more than 1.5m hours of commissioned home care could not be provided between August and October because of a lack of staff, despite record growth in provision

– one in two councils has had to respond to a care home closure or bankruptcy over the past six months

– more than 40,000 people have been waiting longer than six months for an initial assessment

And with a record number of adult social care vacancies already documented across England – thought to be around 100,000 – the Nuffield Trust thinktank this week warned of a "deepening crisis", as it unveiled its own research showing that the social care workforce shrank by up to 70,000 between April and October this year.

Low pay levels in social care are a major recruitment obstacle – skilled carers can earn more working in supermarkets or Amazon warehouses – but an estimated 32,000 staff may also soon

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leave the sector because they don't want to be double-vaccinated. Members of the Homecare Association have warned that this government-imposed vaccine mandate will reduce their staff rosters by more than 25 per cent.

Looking ahead, adult social care charity Skills for Care has also estimated that the sector's workforce needs to grow by 30 per cent – almost 500,000 extra jobs – to match the projected number of people reaching the age of 65 by 2035.

Funding shortfall

The government's reluctance to invest heavily in social care has long been the case. Aside from outlining details of the forthcoming National Insurance health and social care levy, which will offset the costs of the cap on care home costs, the press release for this new plan makes sparse reference to extra funding for the sector.

That's hardly surprising, as ADASS president Stephen Chandler told attendees at the recent National Children's and Adult Services Conference that only two per cent of the funding to be raised by the levy next year will go to pay for social care – that's against a sector shortfall estimated by the Health Foundation charity at somewhere between £6bn and £14bn.

Equally worrying, the Department of Health & Social Care (DHSC) sales pitch for the new plan suggests local authorities will have access to sustainable funding partly through "long-term efficiencies" – normally a euphemism for cuts.

At the same time, the new plan puts councils – already financially stressed after a decade of austerity measures (spending on adult social care remained more than four per cent lower in 2018/19 than in 2009/10, despite a 17 per cent growth in the size of the population aged 80+ over the same period) – under further pressure by scrapping the system which obliges self-funders to pay more (up to 40 per cent more, according to the King's Fund) for their care than when it is funded through local authorities.

Private care providers – more than half of elderly care home residents pay all or some of their fees, and 82 per cent of places are provided by for-profit operators, according to research company LaingBuisson – will surely resist such a move, suggesting that councils may end up having to subsidise self-funders in order to insure against further home closures.

More integration on the way?

Elements of the government's approach to health and social care integration, largely missing from the paper presented in the Commons this week and therefore likely to emerge in the follow-up (but so far unscheduled) document, started to leak out in the days following the Commons care cap vote the previous week.

A policy paper was announced the day after the care cap vote by the DHSC calling for "ever closer working between NHS organisations and local authorities", with the review team behind the paper scheduled to report to health secretary Sajid Javid by next March. The accompanying press release promised that a "delivery plan with clear timelines" would follow shortly afterwards.

The HSJ news site fleshed out the DHSC's thinking the same day, floating the idea of jointly managed health and social care planning in each integrated care board area, with staff reporting both to the NHS and to local councils – a move which would require the pooling of both services' budgets.

Later last week more details surfaced, this time directly from the health secretary, as well as from NHS England chief executive Amanda Pritchard, when they both addressed delegates at the National Children's and Adult Services Conference. Javid outlined a proposal to create more joint roles across the health and social care sectors, while Pritchard talked of extending the joint NHS/local council 'urgent community response team' concept piloted earlier this year.

History lesson

But whatever appears in the follow-up paper on integration, it's difficult not to conclude that the crisis in the adult social care sector stems largely from the creeping privatisation of health and local government services that has been part of the Tory project since the late-1970s.

Just consider this: when Margaret Thatcher swept to power in 1979 the proportion of residential and nursing care services provided by the state was 64 per cent, but by 2012 this had fallen to just 6 per cent. And the private sector provided just 5 per cent of state-funded domiciliary care services in 1993, a figure that had risen to almost 90 per cent by 2012.

This was achieved by restricting the funding available to local authorities to provide care services, forcing them to generate 'efficiencies' by entering into deals with the lowest-cost operators in the independent sector, in the process driving down the quality of care. In 2013 the Centre for Health and the Public Interest (CHPI) elaborated on this approach:

"In the case of domiciliary care, local authorities were placed under a duty to demonstrate 'best value' in the services they provided. This meant that they were required to compare the cost of providing their own services with the cost of having them provided by the private sector, and because much the largest part of domiciliary care costs are in employing care workers, the lower rates of pay in the private sector meant that councils could achieve significant savings through outsourcing this service."

As for nursing and residential care, the CHPI noted that, "From 1993 central government gave local authorities grants to pay for

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Vaccination inequity driving continuing Covid threat

The spread of the Covid-19 variant, Omicron, across the world, is a reminder that mass vaccination programmes have failed to reach a large proportion of the world's population; Covid-19 has continued to spread out of control allowing numerous mutants to develop and the oft-used phrase no-one is safe until we are all safe is proving very apt indeed.

But it did not have to be this way - the world has produced more than enough vaccine to vaccinate the global population. Why this has not happened is down to the inequitable distribution of vaccines - the high income G20 countries, including the US, the EU, and the UK have used or hoarded 89% of all vaccine produced. This has enabled them to undertake mass vaccination campaigns that are now into giving third or booster vaccinations. In contrast, poorer nations have not reached 30% vaccination rates and in many cases are much lower (fig 1). By the end of November, South Africa had managed to fully vaccinate just 24% of its population and Africa as a whole was at 7.3%, with several countries within the continent at much lower rates of vaccination.

Yet in 2020, Covax was created, a scheme run by UN agen-

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cies, including UNICEF, and the World Health Organization (WHO), to ensure that Covid vaccines are made available around the world, with richer countries subsidising costs for poorer nations. COVAX's initial target was to distribute enough vaccines to protect at least 20% of the population in 92 low- or medium-income countries - starting with healthcare workers and the most vulnerable groups.

Additional pledges were then made in June 2021 at the G7 summit in Carbis Bay, UK, and in September 2021 at the Global COVID-19 Summit. At the summit the WHO, the Group of Twenty (G20), and other participants endorsed the goal of achieving 40% vaccination coverage in every country by the end of 2021, and 70% coverage by mid-2022.

The vaccine pledges hit the headlines, but the actual vaccine doses have not reached the target countries in sufficient amounts to make any dent in the pandemic.

The recently released report Holding the World to Account: Urgent Actions Needed to Close Gaps in the Global COVID-19 Response - produced by COVID GAP, an independent organisation based at Duke University, USA, notes that taken together, the G7 countries have shipped about 319 million donated doses by November 2021, which is only about 20% of what the countries had collectively pledged (Fig. 2).

Based on current vaccination rates, nearly all low-income countries, including most African countries, are not on track to reach the 40% vaccination target by the

end of 2021. In contrast, almost all (96%) high-income countries have already achieved 40% coverage, and most are far beyond this target. Among the 92 countries covered by the COVAX Advance Market Commitment (AMC92 countries), a system to supply countries with vaccine pledged by high income countries, the median vaccination coverage is just 11%.

The COVAX GAP report notes that:

"With less than seven weeks left in 2021, the outlook for these countries is grim. The 40 percent vaccination target will not be reached during 2021 or even by early 2022 without a clear action plan at local, regional, and global levels, significant increases in vaccine supplies, and the resources and capabilities to distribute and use them."

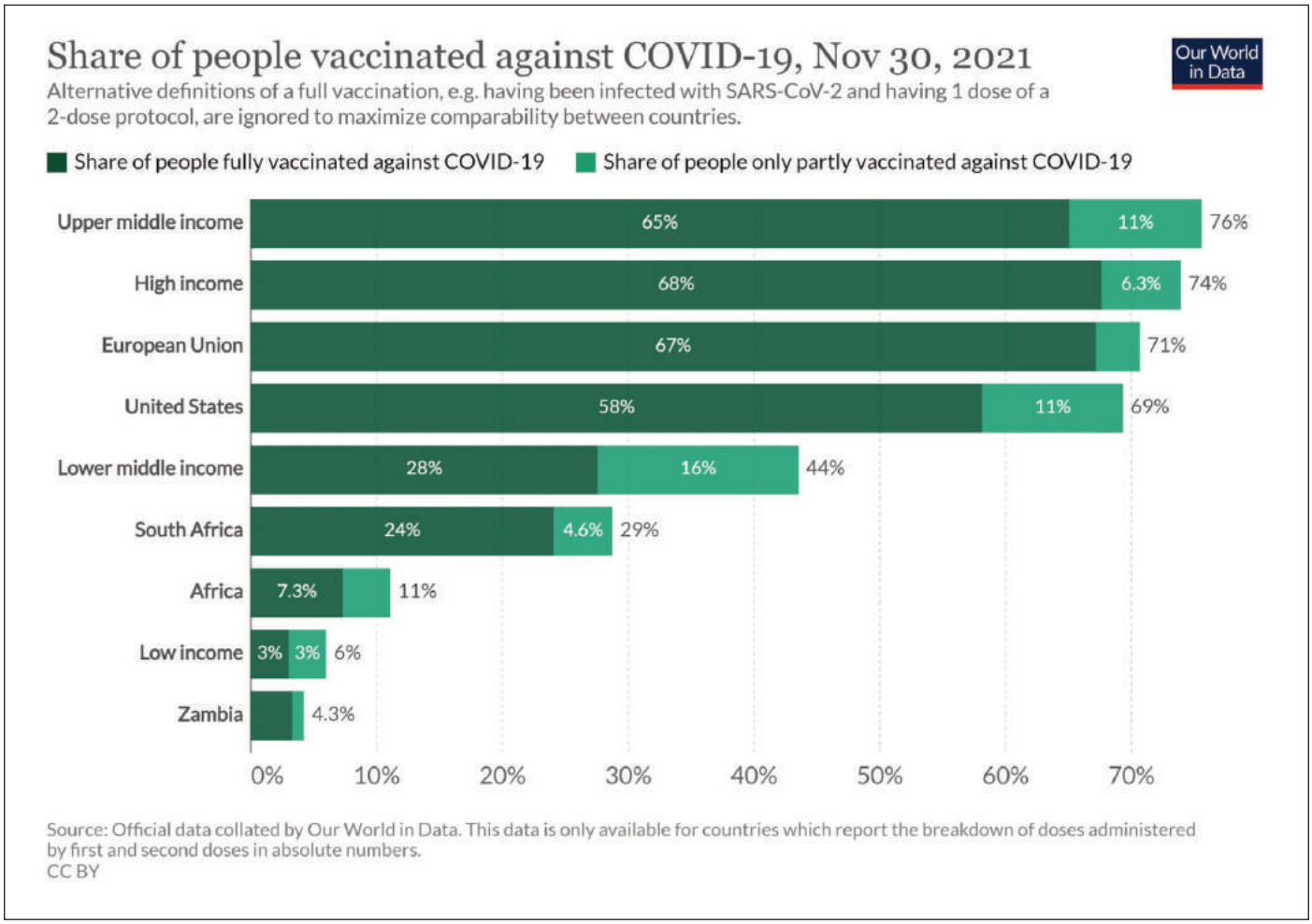

Figure 1

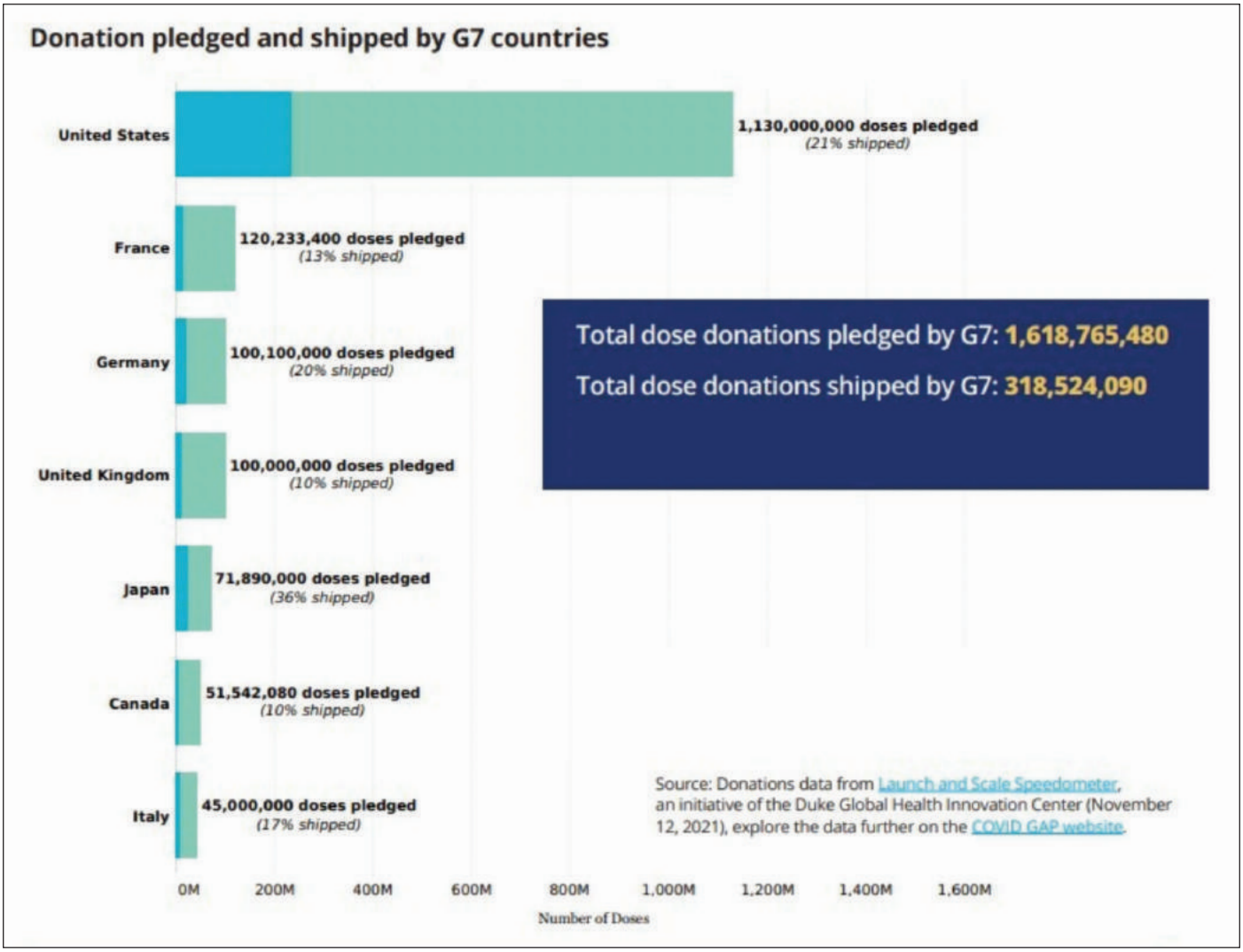

Figure 2

The COVAX GAP report notes that the 40% target requires 650 million doses of vaccine can be achieved by the diversion of vaccine away from the G7 and EU countries to lower income countries. The team at COVID GAP has calculated that if all the excess doses available in G7 and EU countries (834 million doses) were to be diverted to low-middle income countries (LMICS) there would be enough vaccine to fully close the 650 million dose supply gap.

This diversion could be achieved by "queue shifting" - when developed nations defer delivery of their supplies so that they can be sent to lower income countries. The US has recently deferred delivery of some of its contracted Moderna doses to prioritize dose delivery to the African Union and at the end of November, Switzerland agreed to move further down the queue for delivery of the Moderna vaccine. Now 1 million doses of the Moderna vaccine originally planned to be delivered to Switzerland will instead be made available to COVAX. Switzerland will then take COVAX's place in the queue, and receive these doses later in 2022. Although a good move, it is not nearly enough.

The reluctance of rich countries to donate vaccine, despite pledges to do so, is not the only issue with the COVAX system.

The majority of the donations to-date have been ad hoc, provided with little notice and short shelf lives, it has been severely challenging for countries to plan vaccination campaigns. Under these circumstances it would be difficult in developed nations, but in countries with limited healthcare systems, poorly developed cold chains and transportation networks, then the burden becomes almost impossible. The African Vaccine Acquisition Trust (AVAT), the Africa Centres for Disease Control and Prevention (Africa CDC) and COVAX have jointly called for the quality of donations to improve, with not just vaccine donations but other essential supplies, such as syringes. The countries need a predictable and reliable source of vaccine that can be used for a long-term sustainable vaccination programme.

It is clear to many that the COVAX system, which relies on the generosity of the governments of rich nations, is never going to

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solve the issue of Covid vaccination for Africa or any other poor nation. But there is another way - give these nations the ability to make the vaccines themselves. Countries such as South Africa and India have the infrastructure to manufacture the vaccines, the only thing standing in their way is intellectual property rights (ipp or patents) and a lack of help from the innovator pharmaceutical companies.

In late 2020, India, the country in the best position to increase vaccine production quickly, and South Africa introduced a proposal to temporarily waive intellectual property rights on COVID-19 vaccines and therapies at the WTO (World Trade Organisation), but negotiations became deadlocked in the face of opposition from many developed countries. More than 100 countries backed the waiver saying it will save lives by allowing developing countries to produce COVID-19 vaccines. But a handful of countries, including the EU and the UK, and some hosting major pharmaceutical firms such as Switzerland, were opposed.

In May 2021, hope was kindled that patents covering the vaccines would be waived, when the US administration said it backed a temporary waiver of international patent protections for COVID-19 vaccines, but little progress has been made since.

Pressure has been building over the past few months however. The last few weeks has seen the EU move closer to a deal, according to a Euronews report, which notes that the European Commission is now "ready to go beyond" its initial position, "to get consensus on a waiver that makes sense [and] that will increase production".

The appearance of the omicron variant led US President Joe Biden to once again call for a waiver on patents. The UK government, on the other hand, continues to be opposed to a patent waiver. When questioned in Parliament recently by Green MP Caroline Lucas, Sajid Javid, the Health Secretary said a patent waiver would not be 'helpful'.

This week nursing unions in 28 countries filed a formal appeal with the United Nations over the refusal of the EU, UK, Norway, Switzerland and Singapore to temporarily waive patents for Covid vaccines. The letter, coordinated by the healthcare umbrella organisation Global Nurses United, and Progressive International, cited what it called an "immediate threat to people's right to health".The appeal noted the lack of a patent waiver had contributed to a "vaccine apartheid" in which richer nations had secured at least 7bn doses, while lower-income nations had about 300m.

At the same time, over 230 public health professionals have also written to The Times urging all countries to waive intellectual property rights, saying that not to do so was "grossly unjust and undermines the international effort to combat Covid-19."

Negotiations on a targeted waiver were scheduled to begin on the 30 November in Geneva at the WTO, but the Washington Post reports that due to the Omicron variant, the talks have been postponed with no new date set.

While there was a deadlock between countries on patent waivers at the WTO, there has also been little help for the poorer nations from the innovator pharmaceutical companies, which could just license out their technology and advise on production.

Soumya Swaminathan, the WHO's chief scientist, asked companies to contribute their intellectual property to the Medicines Patent Pool, an organisation, backed by the UN, which works to bring together innovator companies and reliable manufacturers in developing nations. But according to a recent article in Nature, pharmaceutical companies have refused to join; Thomas Cueni, the director-general at the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA), cited quality control and quality assurance being an issue with this approach.

The only country that has wholeheartedly shared its vaccine technology is Russia, which has granted a broad license to the Sputnik V vaccine to 34 drug companies outside its borders, including in India and Brazil. However, this is not the easiest of vaccines to make, as the second dose of the vaccine has a different composition than the first and it is proving difficult to produce in large quantities.

With no widespread patent waivers and little to no help from the innovator companies, the developing nations have had to essentially go it alone.

In June 2021 the World Health Organization (WHO), COVAX and a South African consortium comprising Biovac, Afrigen Biologics and Vaccines, a network of universities and the Africa Centres for Disease Control and Prevention (CDC) established its first COVID mRNA vaccine technology transfer hub. Back in October 2020, Moderna pledged not to enforce its patents during the pandemic and this news, plus a large amount of publicly available information on the Moderna vaccine, meant that the first target for the hub was replication of the Moderna vaccine.

However development has not been easy, the lead company Afrigen Biologics and Vaccines has had to rely on publicly available information, help from the WHO and international consultants, including the US National Institutes of Health, as Moderna has refused to part with any information about how to make the vaccine. As a result, what could have taken one year to complete is now likely to take around three years and there is still uncertainty around what will happen when the team reach phase 3 trials of the vaccine - will Moderna allow them to go ahead

The severity of the omicron variant and whether the current vaccines will protect against it is, as yet, unclear, but what is clear is that unless rich countries fulfill their pledges to poorer nations and increase the speed of mass vaccination, omicron will not be the last variant to sweep across the globe undermining all our efforts to protect our populations - **no-one is safe until we are all safe**.

Pathologists call for boost to NHS capacity amid widespread outsourcing

The government's recent funding announcement aims to expand the diagnostics capacity of the NHS focused on the opening of at least 100 community diagnostic hubs across England, expanding partnerships with the private sector, but will NHS pathology be left out?

The new money was welcomed by the Royal College of Pathologists, however Professor Mike Osborn, President of the Royal College seemed less confident that NHS pathology services would get the share of it they needed.

"It is absolutely crucial however, that pathology services are allocated a portion of the new funding to help further workforce expansion, investment in IT and digital solutions. Without it, it will not be possible to tackle the backlog irrespective of how much is invested in other types of diagnostic centres, such as imaging. Increasing the latter, whilst necessary, will ultimately lead to significant increase in referrals to the already stretched pathology services for additional investigative tests, necessary for patient management.'"

Around 95% of clinical pathways now rely on access to pathology services. The tests are crucial to the early diagnosis of many conditions, including cancer, diabetes, heart disease and rare genetic disorders. Pathology services play a vital role in early detection as an essential part of NHS care, which in turn improves the chances of successful treatment and most importantly, saves lives. Around 1.2 billion pathology tests are carried out in England each year.

In a recent interview with the Financial Times, Professor Osborn warned that prior to the pandemic pathology services were stretched following years of underfunding, with a failure to invest in both technology to allow tests to be read remotely and in increasing the workforce. Professor Osborn spoke of a "workforce crisis" as a quarter of histopathologists who diagnose disease aged at least 55.

In a Royal College of Pathology workforce census released in 2018, of the 103 histopathology departments that responded to a survey, only 3% said they had enough staff to meet the current clinical demand and 45% of departments had to outsource work, while 50% of the departments were forced to use more expensive temporary workers.

Pathology services that have been underfunded for years are now expected to rise to the challenge of helping eliminate the backlog of work due to Covid-19 and an onslaught of work from over a 100 new community diagnostic hubs which will

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be dependent on their services. The NHSE-commissioned review of diagnostic services published in October 2020 recommended a major drive to expand the pathology workforce, specifically histopathologists, advanced practitioners and other healthcare scientists, plus upgrading pathology and genomics equipment and facilities to allow the introduction of new technologies.

One would hope that this report would have triggered a major investment in pathology services, but the big recent spending announcements are on diagnostic imaging and only around £40 million appears to be allocated to pathology and this is to digitise services – nothing for workforce expansion.

The concern is that the changes that took place in 2020/21 – the setting up of the Lighthouse Laboratories – several run by or involving non-NHS organisations – and the influx of private companies to carry out testing, will through necessity become the preferred approach to expand capacity as the NHS attempts to treat the backlog due to the pandemic.

Pathology services already have a history of privatisation; over the past decade or more a slow consolidation process has taken place to form what is known as the hub-and-spoke model of working. This has also encouraged private/public partnerships. There are now four of these partnerships around the country, with the German company Synlab, also known as iPP, being a major partner in three of them.

Privatisation strategy revealed

In November 2020, Matt Hancock, the then Secretary of State of Health and Social Care, said that the Lighthouse Labs will represent a permanent part of the UK's new diagnostics industry. Many of the Lighthouse labs operate with private companies so could these be part another wave of public/private partnerships.

The one at Alderley Park is run by Medicines Discovery Catapult, in Glasgow the lab is run by BioAscent, in Milton Keynes the lab is run by the not-for-profit UK Biocentre, and the lab in Loughborough is operated by Perkin-Elmer. In July 2021, the first of a network of new mega laboratories, in Leamington Spa, began operating, although this is run by the NHS.

The DHSC has admitted that the Lighthouse lab network is entirely separate to England's existing complement of NHS and PHE laboratories, although it claims NHS trusts remain as potential 'suppliers'.

Back in January 2021, The Lowdown reported that the professional body representing laboratory staff, the Institute of Biomedical Science (IBMS), expressed concerns over the plans for the mega laboratory.

Shortly afterwards biomedical scientists and members of Unite the union raised concerns about standards and practices in a report on the new mega lab in Leamington Spa.

Poor standards and questionable contracts

Serious concerns over the quality of work carried out at the Lighthouse Labs were raised in May 2021 when an undercover reporter for BBC's Panorama which found one of the UK' s largest Covid testing laboratories in Milton Keynes could be returning false results due to contamination and lack of quality control.

Numerous private companies are also involved in testing for Covid-19 outside of the Lighthouse Lab network. Most were awarded contracts under emergency procedures without a competitive tendering process and led to allegations that the allocations of contracts was influenced by political connections rather than experience in the area.

A good example is Randox, a diagnostics company that paid the Conservative MP Owen Paterson as a lobbyist. It managed to win a £133 million Covid-19 testing contract days before government officials concluded that it did not have enough equipment. Documents seen by journalists at The Times contained officials explaining that university campuses would have to give up testing resources and send them to Randox.

Under the contract, the Randox sent kits to the public and places such as care homes and they were delivered back to Randox for testing. However, in July 2020, the testing kits were withdrawn after safety problems were discovered. Despite this in November 2020 the company was given a 6 month extension contract worth £347 mn.

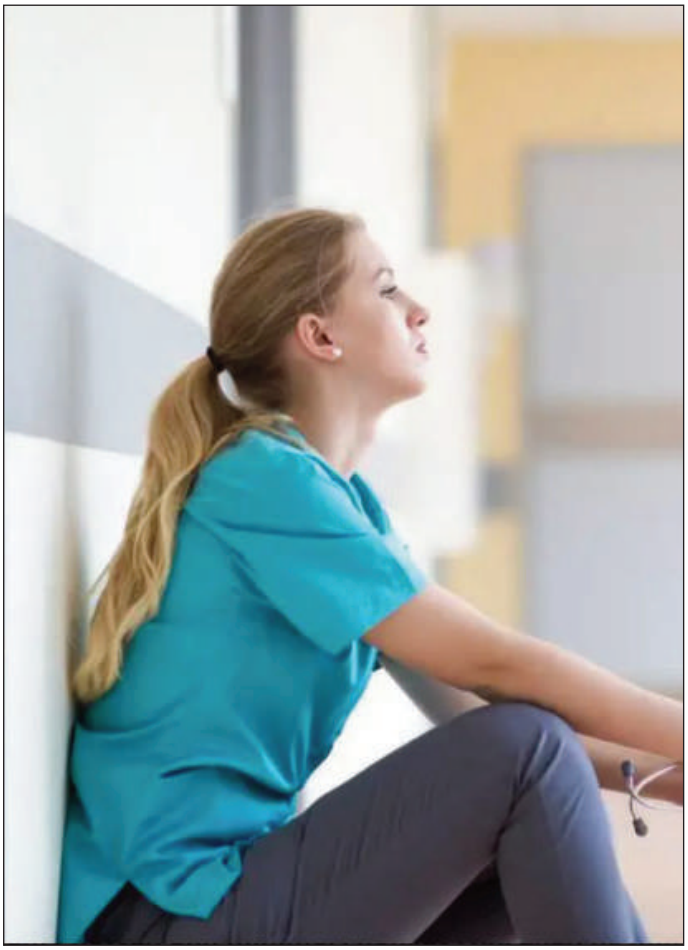
Then there is Immensa, a company set up near the start of the pandemic in May 2020. Three months later, the Department of Health awarded it a £119m PCR testing contract, without a competitive tendering process. In October 2021 operations at the Wolverhampton lab were suspended as it was found the company had given out 43,000 incorrect test results between 8 September and 12 October.

Since the testing errors have emerged it was found that Immensa was not fully accredited with the UK Accreditation Service. Its sister company, Dante Labs which does travel tests is also the subject of an investigation by the Competition and Markets Authority.

Just a few days ago The Independent reported that a whistleblower at Immensa's lab in Loughborough had made numerous allegations of wrongdoing, with no formal staff training, staff allegedly forced to operate faulty machines without proper protective equipment, risking cross-contamination and spoiled samples.

John Lister

Few concessions on Health & Care Bill – the fight goes on



Now Tory MPs have rubber stamped a deeply flawed Health and Care Bill with no opposition amendments passed and minimal changes conceded by ministers, the focus for opposition to it will shift to the House of Lords.

The fight over the controversial issues is important, both to expose as widely as possible (and warn a wider public and the NHS staff) what new problems are coming down the line, and to make it absolutely clear that each and every negative consequence that flows from the Bill is down to ministers and the Tory MPs that vote it through, and nobody else.

According to a document leaked to the HSJ, it appears that NHS England is concerned that the tight schedule to launch Integrated Care Boards by April next year, when legislation may not have been finalised until late February or March could force a delayed launch of the new system.

The last minute addition into the Bill of the controversial proposals to introduce an unfair system to "cap" social care spending for the wealthy, offering little if any benefit to those on low incomes dependent on local authority funding, or with smaller assets and lower-priced housing, could yet be a factor in holding up progress.

But even if this happens, and as a result some amendments are carried in the Lords and even accepted by the Commons, at the end of the process a government with a majority of 80 will get the core elements of its Bill through.

Campaigning lessons

So whatever is passed we will have to find ways to fight on to repair and restore our battered NHS – just as we had to do back in 1991 as John Major's government broke the NHS into an "internal market" of purchasers and providers, and in 2012 after Andrew Lansley's wide-ranging and fundamental Health and Social Care Act was forced through by the Tories, propped up only by the spineless LibDems.

That legislation set out to entrench privatisation and outsourcing, a competitive market system in which local commissioning groups were forced to put an ever-growing range of clinical services out to competitive tender. Lansley's fundamentalist neoliberal supporters gleefully hailed it as the start of the "denationalisation" of the NHS. Happily they were subsequently disappointed.

The 2012 Act replaced Primary Health Trusts as local commissioning bodies with 207 newly-created Clinical Commissioning Groups, in theory 'led by GPs': it also scrapped Strategic Health Authorities, and with them any coordination or planning.

It ended the direct accountability of the Secretary of State for the promotion and provision of health services in England, which was transferred to an 'arm's length' body, NHS England – although in practice Health Secretaries have continued to behave as if they were still in charge.

It gave foundation trusts new "freedom" to make up to half of their income from private patients and other work outside the NHS, scrapping previous tighter restrictions.

But in practice, vigorous resistance to the Bill by campaigners was followed by increased local scrutiny and exposure of every move by CCGs, every contract they signed, and every company seeking or winning contracts.

That, coupled with frequent private sector failures and continued public opposition to privatising NHS services, helped to limit how far the key Lansley plans could be fully rolled out.

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An initial flurry of contracting led to an increase in numbers of private contracts, especially relatively low value community health contracts: the number and total value of contracts did increase, but the share of NHS spending on for-profit providers plateaued in 2015 and has even fallen slightly. Only by including the whole of spending on GP services can the total spent on non-NHS providers prior to Covid reach 26%: without the GPs it comes to 18.5%.

Clearly this level of spending on private provision of mental health, elective care and contracted services is way too high, and the NHS could more efficiently deliver better coordinated services if the contracts were brought in house along with the necessary investment.

But years after Lansley the vast majority of NHS services – and the whole of emergency health care services – are still delivered by NHS providers, with private companies unwilling to touch most of this work for fear of eroding their profit margins.

Since 2014, just over a year after the Act came fully in to force, NHS England's focus shifted from competition, markets and the private sector, to 'systems' and coordination between providers and commissioners, reducing fragmentation. Now there is no visible lobby seeking to uphold and continue with the legislation the Tories fought so hard for in 2011-12.

Instead we saw the abortive drive in 2016-17 to reorganise England's NHS into just 44 "Sustainability and Transformation Plans"; then mergers of CCGs, coupled with pilot projects establishing so-called "Integrated Care Systems" from 2018; and the Long Term Plan in 2019.

The Plan was linked to a campaign by NHS England for new legislation, to remove sections of the Lansley Act requiring competitive tendering, and to give legal powers to 42 'Integrated Care Systems.'

Partial progress on outsourcing

The new Bill does end some tendering, but pulls up well short of abolishing outsourcing and privatisation, or making the NHS the default provider, as proposed by the unions. It only abolishes competitive tendering for clinical services (of which only an estimated 2 percent have been going through with tender processes anyway), and does not roll back any existing contracts. An amendment reinserting regulations to limit the danger of a new round of shameless crony contracts has been rejected.

Numerous controversial proposals were added to the Bill by former health secretary Matt Hancock, extending and adding new powers of the Secretary of State on a wide range of issues, including intervention in local hospital closures and reconfiguration of services.

The Bill scraps the legal right in the Care Act (suspended last year during the Covid peak) for vulnerable patients to have their needs fully assessed before they are discharged from hospital, posing real dangers of patients being left stranded at home by inadequate social care, community and primary care services.

Ministers have responded to criticism that the Bill is a 'corporate takeover bill' by tabling an amendment to prohibit anyone "involved with the private sector or otherwise" from taking a seat on an Integrated Care Board if this could be "reasonably regarded as undermining the independence of the health service". But an amendment to similarly keep private sector representation out of all ICB decision-making bodies has been rejected, and an amendment to exclude GP employees of private corporations from ICB GP seats also failed.

With just 42 ICBs as "local" bodies, some spanning large areas and populations as large as 3 million, and no explicit requirement to establish more local "place based" structures, England's NHS will be less locally accountable and less open to scrutiny than it has been since the early 1970s.

Amendments calling for ICB chairs, who will have considerable powers, to be elected on similar lines to police and crime commissioners were brushed aside. Instead chairs will be imposed top-down by NHS England, and accountable only upwards, not downwards to local communities: they can be removed only with agreement of the Secretary of State.

The Bill reorganises the NHS – but it does not fundamentally change the system established in 2012.

It does not "sell off" the NHS, although services will still be contracted out, not least where capital investment is required to develop new centres or services. Private hospitals and contractors do not seek to own, but feed off and profit from the NHS.

Any increased role of the private sector or major outsourcing of contracts once the Bill becomes law is almost certain to be closely watched and scrutinised – with just 42 ICSs to keep track of, and a horde of campaigners in each, alert to the slightest whiff of cronyism or privatisation and ready to sound the alarm.

The fight goes on, to the Lords – and beyond.

But the bill is far from the only, or even the biggest problem faced by the NHS. A wider fight also has to be waged on the ground in every part of the NHS, where 12 years of cash starvation coupled with

Covid has brought services to an unprecedented crisis in which the main enemy is not the private sector but the lack of public investment and NHS provision.

There's still a lot of NHS to defend – and far too much to lose if we don't.

John Lister

...continued from page 2 (People's Covid inquiry)
PPE or any semblance of Health & Safety Executive activity. 1500 health and care workers died. In London alone, dozens of bus drivers died.

It was unions like the GMB, NEU and ASLEF who were actively protecting their members at work, not Government, not employers. The inquiry heard how employers let down their staff exposing them to avoidable risk.

Public servants were ignored across the NHS, public health, primary care, care homes, local authorities and schools. Teachers were accused of not caring for children when staff demanded safety in schools. Government redefined and downgraded PPE requirements when supplies were running out, to avoid being accused of breaching employees' safety, and blamed NHS and care staff for abusing PPE.

Private contracting was the preferred route to procure supplies and services, from NHS Test and Trace at a cost of £37 billion wasted (run by Serco, Sitel and Deloitte) to setting up private, often unaccredited laboratories, instead of urgently boosting NHS capacity.

The private hospital sector's costs were underwritten and no more than 30% of their capacity was used. The level of government cronyism and resultant profiteering has been blatant and in plain sight.

Breach of public trust

The Government had no time for a public inquiry but time to rearrange the NHS mid-pandemic, with its dangerous Health and Care Bill. Government treated bereaved families with disrespect and ignored their questions for over a year.

If and when the Government's judicial-led public inquiry convenes (no chair or terms of reference at the time of writing), Jo Goodman, Co-Founder of Covid-19 Bereaved Families for Justice (who contributed to the Inquiry) argues:

"It's vital that bereaved families are at the heart of the forthcoming inquiry and listened to at every turn, and this report evidences exactly why. The loss of our loved ones should be used to learn lessons and save lives – something the Government should be entirely focused on and dedicated to."

Lessons to save lives

The Inquiry set out to learn the lessons that could save lives in this and future pandemics. The Panel has been shocked at the avoidable loss of tens of thousands of lives through the neglect of pandemic planning, the run-down of the NHS, and the intense inequality in this country and the wider impact this has had.

All this has left the NHS and Care sectors at existential risk of collapse. Equally shocking has been the breach of all the Nolan Principles of behaviour in public office, including lack of candour, honesty and integrity.

The overall conclusion of the Inquiry is that there has been misconduct in public office. This has to be addressed: if it is ignored, the country cannot learn the lessons from today to face the challenges of tomorrow.

If the NHS, Care and support services and inequalities are not addressed the future for the population is bleak. Keep Our NHS Public believes that these findings are an important contribution to what must change and change now.

The report will be submitted to government and the future public inquiry in the hope that its contents may help inform future policy.

Tony O'Sullivan, co-chair KONP

Watch the report launch at https://youtu.be/S56rrfgFWFg or download report at https://www.peoplescovidinquiry.com/

...continued from page 8 (Adult social care)
nursing and residential care and other forms of community care, including housing, but on condition that 85 per cent of the money had to be spent on care homes and other community care services not run or owned by local authorities.

"In addition, successive governments denied local authorities sufficient capital funds to either build or maintain their existing residential care homes, so that as new care standards were introduced – which local authority homes did not meet – large numbers of publicly-owned care homes were transferred to the private sector to own and run."

Similar budgetary and legislative pressures continue to this day, albeit on a more subtle level. Alongside talk of home adaptations, new websites and remote monitoring technology, the People at the Heart of Care document ominously suggests future funding for local authorities may be dependent on them "paying providers a fair rate" – ie potentially subsidising care self-funders – and developing "market-shaping" capabilities.

It also outlines a new duty for the Care Quality Commission to review and assess councils' performance in delivering care, together with new legal powers for the health secretary to intervene "to secure improvement".

So it's hard not to be cynical, given the lessons of the past 40 years, and to worry about the direction the adult social care sector in England is heading. But there are alternatives: a far better outcome would surely be for the UK government to follow Scotland's lead, and consider establishing a national care service.

Martin Shelley

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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