THE lowdown

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

Merseyside staff call to scrap migrant charges

Staff from NHS hospitals in Merseyside delivered a petition on June 17 calling on Merseyside NHS Trusts to stop charging migrants for healthcare. Staff and campaigners have also produced a short video online.

"We are not immigration officers," says Consultant Microbiologist Dr Jonathan Folb in a letter for the campaign, "we are trained to treat patients, but the Hostile Environment is interfering with our work to deliver care."

Merseyside Action for Migrant Healthcare has won support from Liverpool MPs Kim Johnson, Dan Carden, Paula Barker and Ian Byrne. The petition has been signed by staff and hundreds of Liverpool residents.,

Although COVID-19 testing and treatment is free, the test can fail to detect the disease, and patients may have other health problems whose treatment is not free.

Long before COVID-19, women were missing antenatal appointments to avoid being charged or reported to the Home Office.

This call for action on migrant health comes amid national controversy over disproportionate deaths from COVID-19 amongst BAME communities in the UK and widespread anti-racist protests as part of the international Black Lives Matter movement.

Infectious Diseases Registrar Dr Chinenye Ilozue said: "We are asking NHS Trusts on Merseyside to do the right thing."

Will "temporary" closures and cuts ever be reversed?

John Lister

With tens of thousands of NHS beds still closed (NHS Improvement has refused to reveal an updated figure since the Health Service Journal in April revealed 37,000 beds were unoccupied) NHS England's focus appears to be on a multi-billion pound deal to utilise private hospitals.

This raises serious questions over the future of the many services including A&E departments "temporarily" closed during the peak of the Covid crisis, many of which NHS bosses had sought to scale back in previous plans.

Protests

There have been protests in Grantham in Lincolnshire over the downgrading of its day time only A&E to an Urgent Treatment Centre, with emergency admissions diverted to Lincoln or Boston, each 30 miles away.

Questions have been asked in the Commons over the "temporary" closure of already reduced A&E services in Chorley, Lancashire, and concerns have been raised locally over other "temporary" closures of A&Es in Cheltenham and Weston super Mare, and emergency surgery in Ealing Hospital.

Campaigners fear that the relocation of ICU staff to work in Basildon could herald the downsizing or closure of Southend's ICU.

Staff in Southend Hospital, now merged with Chelmsford's Broomfield Hospital and Basildon & Thurrock hospitals into a mega-trust covering Mid and South Essex, last week also raised fears that the relocation of ICU staff to work in Basildon could herald the downsizing or closure of Southend's ICU.

They fear this could indicate a renewed drive by the merged trust to implement the "centralisation" of specialist and emergency services in Basildon, plans for which were abandoned in 2017 as a result of mass public pressure.

The Trust has issued a statement to staff that does not specifically answer these concerns, but makes clear that:

"A key part of ensuring we can sustain as much non-COVID related healthcare as possible – prioritising urgent, emergency and cancer care - will be through concentrating specialist

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"Temporary" closures and cuts – from front page

The fight to save and fully open Chorley's A&E has been running since 2016

COVID intensive care at Basildon." Local Save Southend NHS campaigners are watching closely.

Other "temporary" closures that may well prove permanent include a children's ward at King George Hospital in Ilford, a children's A&E at Solihull's Good Hope Hospital, and the closure of all 10 beds at Lutterworth Community Hospital in Leicestershire.

Management assurances in each case that these closures have been made necessary by the Covid pandemic would have been more credible if not for the long history of plans in these areas to centralise emergency services and downgrade other sites.

Grantham

In **Grantham** the District Council is to meet to respond to the latest changes, and "a good few hundred" local people turned out on June 15 to protest at the decision by United Lincolnshire Hospitals Trust to downgrade the A&E to an urgent care centre as part of plans to make the hospital Covid-free.

Cllr Charmaine Morgan, who chairs the SOS Grantham Hospital campaign group, told Lincolnshire Live: "We are concerned that A&E will be lost forever. The trust has been attempting to downgrade A&E to an urgent treatment centre for at least five years."

She went on to express concern at the loss of two medical wards at Grantham, with treatment of more than 1,000 patients moved to Lincoln and Boston hospitals, and said: "If we lose the staff from these wards we lose the back-up for our A&E."

Lincolnshire Live reports one nurse who posted on Facebook: "Grantham staff who went to Pilgrim etc during the height of the Covid crisis to work in and run Covid-positive areas have been told their jobs at Grantham have gone, their wards/departments closed and they will be being moved to another site."

On the June 15 protest campaigner Jody Clark told Lincolnshire Live that while protesters understand the need to create a safe site for vulnerable patients, the Trust's plan would leave much of Grantham Hospital closed, despite the fact it has a number of entrances and exits to easily allow services to be separated.

Lincolnshire's waiting list has more than doubled during the Covid crisis, from 5,000 to 12,000. The Trust insists that the downgrade is only temporary, and due to run until the end of March 2021.

Chorley

Health Secretary Matt Hancock has given a formal commitment in the Commons that **Chorley's** "temporarily" closed part-time A&E will also reopen, although no time frame has been set. Here too plans to permanently downgrade the A&E, and use the Chorley site only for elective patients have been hotly debated for years.

Chorley's MP is Commons Speaker Sir Lindsay Hoyle – and has been working with other local MPs to resist the pressure to downgrade the hospital. Sir Lindsay welcomed the health secretary's comments about reopening the A&E commitment", but stressed that "the pressure [will] remain until that happens".

The A&E closed in 2016 on grounds of staff shortages, triggering a storm of local protest that forced a partial reopening, but trust bosses and local commissioners have continued to favour options that would close the full A&E and critical care beds at Chorley.

Last August a document assessing 13 options for the future of hospital services in Chorley and Preston was published arguing it was not "clinically viable" to retain accident and emergency facilities at Chorley.

However it also argued that "It is clear from high-level clinical activity modelling that the population health requirements could not be serviced by one of the two current hospitals" – and there was no money to build a new hospital, or expand either to cope.

Indeed while the report claimed to be "clinically led" it noted that its preferred options were precluded by a lack of capital and the financial plight of the trust.

By January 2020 it was clear that reports by four different sets of clinicians had all come out against the possibility of either restoring a round-the-clock A&E unit or continuing with the existing limited hours service at Chorley.

It seems that the Covid emergency and the lack of normal meetings and scrutiny during lockdown are being exploited to dust off controversial plans

Four reports – similar warnings

But all four reports on Chorley also argued that local NHS leaders were placing too much faith in the capacity of expand primary care and community services to take on some of the services currently provided by hospitals. The Royal College of Emergency Medicine described the hope that this could help manage demand as "wishful thinking".

The RCEM also echoed campaigners' concerns over the "longer travel times for some patients, with uncertain impact on a small proportion with high acuity problems" if emergency services were centralised onto a single site in Preston, and warned that the Preston site would struggle to cope with the workload of emergency medicine and acute/general medicine.

Local MPs were also unconvinced, and have continued to press for the resumption of a full 24-hour A&E: Sir Lindsay suggesting if need be this could be taken over by another local trust. So the announcement in March that Chorley's embattled A&E was once again to be "temporarily" closed came as no surprise, and there is little confidence that the previous service will reopen.

Cheltenham

There is also a history of long-standing plans for reconfiguration and local suspicion among campaigners and politicians in Cheltenham, where plans to "temporarily" divert 999 emergency cases to Gloucester have been announced this month.

Last year plans to remove Cheltenham Hospital's emergency and inpatient general surgery were challenged

by a letter from 57 consultants and senior doctors, stating the move could put patients at risk. A cross-party campaign group called REACH (Restore Emergency at CGH Ltd, led by the Chamber of Commerce) opposed the change, and invited trade unions and campaigners to join in common cause.

Now Chris Hickey, spokesman for REACH, says: "This looks so suspiciously like what we have fought against for six years, in the last two years in particular. Everything they are planning to do are the things we said should be subject to a full consultation."

Ealing

In Ealing Hospital, where campaigners (along with campaigners for Charing Cross Hospital), won a famous victory after a six year campaign when plans by North West London health chiefs to axe both hospitals were finally killed off by Matt Hancock last year, there are fresh concerns over "temporary" arrangements suspend all emergency surgery and close operating theatres at Ealing, and transfer staff to Northwick Park Hospital (part of the same London North West University Healthcare trust).

While there are no doubts that Northwick Park Hospital has struggled to cope, becoming one of the earliest to be swamped by Covid-19 patients, the loss of services in Ealing is a serious blow to its diverse local catchment population, which covers the large BAME community in Southall.

It has forced the suspension of Ealing's highly regarded trauma unit, and increased delays in getting vital surgery, and there are fears it could result in a permanent downgrade of the A&E and acute services.

Ealing Save Our NHS campaigner Eve Turner has written to the Trust noting that their assurances that 24/7 A&E would continue "as they are now" could mean that there would be no restoration of emergency surgery and the previous full Emergency Department.

She notes proposals to reinstate only a day time surgery list, but not emergency orthopaedic surgery.

It seems that a pattern is emerging, in which the Covid emergency and the lack of normal meetings and scrutiny during lockdown are being exploited by NHS managerement to dust off long cherished but controversial plans and create a new fait accompli under the guise of "temporary" measures.

Suspicions will remain until the lost services are put back into place.

Support grows for NHS birthday events

Our NHS deserves better!

This NHS anniversary weekend, Saturday 4th and Sunday 5th July, a coalition of campaigning organisations and trade unions are calling nationwide local events and an online rally on Sunday 5th July at 3:30pm to say: 'Our NHS deserves better.'

The three major health unions, UNISON, Unite and GMB immediately declared support, along with the TUC, with additional support including the Royal College of Nursing, the National Education Union, the Fire Brigades Union, Doctors in Unite and the National Pensioners Convention.

July 5 is the 72nd anniversary of the NHS. It was built after WWII, (a conflict that saw 67,100 British civilians killed) to create something better for us all.

The campaign highlights the fact that after the disruption to services caused by Covid-19, a new generation now faces the challenge of rescuing and rebuilding the NHS to equip it for current and future levels of demand for emergency and routine hospital treatment, mental health and GP services.

During the coronavirus crisis, frontline workers in the NHS and social care have been asked to keep us safe. Too often they have had to do so without proper PPE, within an already failing system, in the lowest paid jobs. Hundreds have sacrificed their lives as a result, while analysis of ONS and official figures by Chris Giles of the Financial Times shows that across the UK population the Covid-19 death toll was 65,400 on June 15.

The campaign publicity from the initiators of the events, Health Campaigns Together, Keep Our NHS Public, The People's Assembly Against Austerity and We Own It, states:

"The NHS deserves better, we all deserve better. Covid-19 has exposed what's wrong with society, it's time to rebuild, and go further. Our '2020 vision' for the NHS says:

- Rebuild and properly fund the NHS
- Proper pay and respect for all NHS and care staff
- End racism in the NHS and end all migrant charges
- NHS out of all Trade Deals
- Public Health back in public hands
- Go further: Radical reform of social care "

Local campaign groups and branches are encouraged to organise a socially distanced protest or a stunt to celebrate the NHS anniversary weekend and say, 'Our NHS deserves better'.

The national online rally on Sunday 5th July at 3:30pm will be streamed live across YouTube channels and social media accounts. More details from Keep Our NHS Public.

NHS deal with private hospitals blocked by Treasury

A £5 billion deal to extend the use of the private sector to treat NHS patients is being blocked by the Treasury according to reports from inside the NHS. The deal, being pushed by Health Secretary, Matt Hancock and NHS England is needed they say to deal with the large backlog of work that has built up during the Covid-19 crisis, which could see the NHS' waiting list rise to 10 million by Christmas.

The *Guardian* reports that an agreement had been reached at the beginning of the month between NHS England and the leading private hospital companies, including Spire, Ramsay and HCA International, but that the Treasury prevented any announcement because it was not satisfied that it represented good value for money.

The new arrangement had intended to extend the deal struck in March, allowing the government to take control of the private hospital sectors' 8000 beds, 680 operating theatres and 20,000 staff, adding to the 3,000 theatres in NHS hospitals.

Under the deal the government paid all operating costs for the private hospitals including rent, external interest payments and staff. This is thought to be costing the DHSC about £400 million a month.

NHS can't "switch on" full capacity

Consensus has grown within the NHS about the need for the extra capacity as managers face up to trying to organise services around the social distancing regulations, which they predict will limit NHS capacity to 60-70% of the maximum, and there is already speculation about whether the deal could become longer lasting.

The NHS Confederation, the organisation that represents NHS managers believes that getting the NHS back to normal involves putting in place "an ongoing arrangement with the private sector" which "will be vital to provide capacity to respond to the backlog of treatment."

It has already warned the government in a letter, that: "It will not be possible simply to 'switch on' NHS services."

Stringent infection control measures will restrict hospital admissions, and managers are reconfiguring wards with less beds. Many older buildings will be particularly difficult to work in due to narrow corridors and smaller rooms.

Often crowded A&Es will have to be redesigned: and gone are the days of large rooms full of people waiting for out-patient appointments.

The changeover times for operating theatres and scans will lengthen as deep cleans will be needed and extra time for donning PPE.

Nigel Edwards, head of the think-tank, the Nuffield Trust told the Independent: "There will still be a major capacity constraint for years to come. We will need to expand the level of elective capacity even to catch up. And I suspect that probably means using the independent sector for at least the rest of this financial year. If not beyond."

"Paid to stand empty"?

Despite the need for extra capacity the *Guardian* reports that Treasury officials remain concerned that over the course of the previous deal the private hospitals were not used adequately and believes the evidence submitted by the DHSC to justify the extension of this deal to the end of the year or March 2021, is flimsy and inadequate.

Under the original contract major private hospitals, including HCA International, BMI/Circle Healthcare, Ramsay Healthcare, Spire Healthcare and Care UK, were supposed to be used for non-Covid work, but doubts have been raised about the extent to which they have been used.

Colin Hutchinson, a consultant ophthalmologist in the NHS and chair of the anti-privatisation campaign group Doctors for the NHS, told the *Guardian* that: "private health facilities have been very, very quiet over recent months. They have been paid to stand empty, by and large."

Consultants in the private sector have told the media that the hospitals have been empty and doctors have been "twiddling their thumbs".

The chairman of the Federation of Independent Practitioner Organisations, which represents private consultants, said: 'The money being poured into the private sector is a total waste."

However, David Hare chief executive of the Independent Healthcare Providers Network argues that private sector hospitals have offered substantial support to the NHS and that their relationship 'has changed before our eyes'.

The NHS Support Federation has sent a letter to the Department of Health and Social Care requesting the full disclosure of this deal and the future plans

Cancer care

In an article for the *Health Service Journal* he cites the transfer of oncology at the University Hospitals Plymouth Trust the local Nuffield Health hospital "which is providing facilities and staff to treat cancer patients and is helping to free up resources in the local Derriford NHS Hospital." and in Southampton the Spire Hospital "is hosting the local trust's entire oncology and haematology services."

In London he says "Bupa Cromwell and HCA hospitals have joined forces with the London "Cancer Hub" to help deliver time-critical cancer treatment to NHS patients."

As yet there are no published figures to show the use of these facilities and the NHS Support Federation has sent a letter to the Department of Health and Social Care requesting the full disclosure of this deal and the future plans.

Earlier figures around the Nightingale hospitals, which included some staff and facilities from private hospitals, showed that around 50 patents were treated in the 4000-bed London unit before it was placed on standby (i.e. closed) at the beginning of May.

10 questions to ask about the NHS deal with the private hospitals

It is not only the Treasury that has questions about the proposed deal with private hospitals: the NHS campaigners will also have many big questions over how the deal would work. Here are ten to get started.

Will the government publish details of the contracts with the private hospitals and allow Parliament to scrutinse them? Commercial confidentially is traditionally cited to keep these deals out of the public view but in March the government also suspended the normal requirement to advertise and award contracts through open competition, so even a partial view has been obscured.

Will the government ensure that a plan to raise NHS capacity runs in parallel with any deal, so that the NHS can take over all work as quickly as possible? NHS beds numbers have been cut in recent years despite rising demand. There is a £6bn backlog in building repairs and a shortfall of at least 100,000 staff and yet there is no credible plan to fund an expansion of services.

How long will this arrangement stand? The Cameron government over saw a vast experiment with private sector involvement in the NHS. Seven years later NHS England called for new law to remove the compulsory tendering of NHS contracts, but no change has happened. NHS expenditure on the private sector still grows and with some concern that without controls the government could exploit this opportunity to expand the role of the private sector.

Will the private sector receive the NHS rate in payment and how will the government prevent the waste that has happening in the past? The NHS tariff sets out the price at which NHS hospitals receive payment, the private sector should not receive more.

There is a precedence for badly made large-scale deals between the NHS and private hospitals - the contracts for the Independent Sector Treatment Centres (ISTC), which were begun with the aim of reducing the waiting lists back in 2003 to 2007 were later found to have wasted taxpayer money to the tune of almost £500 million including a series of 'needless' payments written into contracts that were virtually risk-free for the private companies involved.

How will safety measures in the NHS be applied and checked across private sector sites? A report in 2018 by Centre for Health and the Public Interest identifies what they believe is a systemic patient safety risk within private hospitals.

A deal with Spire and other private hospitals will create fresh public illusions in the private sector

They identify that post-operative care in most private hospitals is carried out by an inexperienced junior doctor, most units lack intensive care facilities and the consultant who carries out the surgery is permitted to be off-site, in some cases 45 minutes away CHPI also contend that the data on patient safety incidents in private hospitals is poor and private hospitals are not required to notify patient safety incidents in the same way as the NHS.

Will the cost of staff training, normally borne by the NHS be reflected in the terms of agreement? The BMA says the NHS Standard Contract should include a clause requiring independent sector providers to contribute towards the education and training of the NHS workforce. In UK the private sector makes use of staff who have been trained in the public sector but makes a negligible contribution to training costs.

How will the government make sure the financial viability of NHS is not affected? NHS hospitals rely on the income from treating patients to sustain their activities. It is therefore essential for their sustainability for the arrangement with the private sector to be time limited.

Who will control the allocations and ensure the best clinical decisions? In the past contracted companies have falsified performance data and there have been accusations that caseloads are manipulated to reduce their costs and operations carried out needlessly

What happens to patients on the waiting lists in areas where this extra capacity is not available? Additional capacity will not always be where the longest waits exist. There is already inequity in provision, how will this be managed?

Can the government guarantee transparency over the operation of this deal? How will the contracts be monitored and information published given the lack of resources traditionally spent on this aspect and the fact that the Freedom of Information Act does not apply to private providers?

Despite the situation the NHS finds itself in, there should be no reason that any deal with the private sector should not be fully scrutinised.

Without adequate scrutiny of the deal, the NHS could simply end up bailing out an ailing private sector – to the tune of billions of pounds.

The evidence so far of the use of the private sector over the past three months shows that the private sector's help for the NHS has been limited, but in exchange it has received millions to pay its debts and operating costs.

Who stands to gain from the NHS deal with private hospitals?

Paul Evans

Millions of patients had their treatment put on hold whilst the NHS battled Covid-19 and waited with considerable anxiety not knowing when their turn would come. They deserve urgent care and if using beds and theatres in private hospitals is the way to guarantee it, then it should be done, but the unremitting desire of governments to outsource and the long record of failures rightly sets off alarms.

The deal should be a time-limited arrangement and certainly not a replacement for the core requirement for a credible new plan to lift NHS capacity.

For a decade the government has ignored the evidence about the levels of resources and staffing needed to match the rising health needs of our community and have run-down key services like public health, hitting the poorest worst.

No more. This new funded plan must start now and run in parallel with any deal done with the private sector.

Bed numbers had been cut steadily for over a decade and before Covid there was a staffing crisis with over 100,000 vacancies, including 40,000 nurses.

For the first time on record, in late 2019, the NHS was missing all its targets, including A&E waiting times, cancer treatment and non-urgent surgery. The waiting list for non-urgent procedures was at 4.4 million, also at a record level.

The NHS needs more than private sector help, but even if the deal is done will they deliver?

The public may rightly question the motives of private companies - that have been positioning themselves to profit from the NHS for years.

Outsourcing in the NHS has delivered a catalogue of failures and examples of companies gaming the system and providing poor value.

Successive governments have made it a pivotal aim to encourage greater for-profit involvement, despite the stack of problems. So forgive the cynics who perceive a glint of opportunism in ministers' eyes at this new deal.

A life line for companies

For the private health providers the NHS deal has been a lifeline, giving them a guaranteed income stream in very difficult times. These companies already rely heavily on work from the NHS - at over 80% of Ramsay's income and around 40% of BMI/ Circle and Spire's income - and this was falling prior to the pandemic as the NHS was instructed to reduce use of the private sector to save money.

With the lockdown came a cessation of all private work - without the March deal from the government the companies would have found it very difficult to survive.

Although they have now been allowed to restart some private work, a worldwide recession beckons, and so making the NHS deal will be an even more important part of their strategy.

Make no mistake, the public should have the upper hand in this negotiation, as many private health companies have suffered flagging fortunes of late and are already being propped up with by £400m a month in public tax receipts, so the government should dominate the terms to make this agreement work for patients and the NHS.

Outsourcing in the NHS has delivered a catalogue of failures and examples of companies gaming the system and providing poor value.

Paying for treatments not delivered

We should learn too from earlier efforts to dragoon the private sector in to help with waiting lists prior to 2010, which whilst contributing to reducing the delays for some patients, resulted in over £200m in payments to providers for treatments that didn't take place.

Don't forget the position of staff, who need continual training, a cost largely born by the NHS. Shouldn't then the NHS be compensated by the private companies who lure staff away?

Improved NHS pay and working conditions are a top priority and would help to reward and keep precious NHS staff.

What about the current NHS Plan?

Whatever your view it has not yet delivered a credible strategy to recruit and retain its workforce, build and repair NHS facilities both in the acute and community sectors, set proper funding, end creeping privatization or put in place accountable structures so that the NHS can be properly planned and run in the public interest.

The NHS and its patients deserve better.

NHS normal activity in January 2020. Unions saying to employers we need to get the NHS back to more normal services – safely

Unions draw up their demands to enable NHS to return to more normal

Steps to safeguard the health of the many Black and Minority Ethnic staff in the NHS are central to a "Blueprint for return" drawn up by 17 NHS unions last month, setting out an agreed joint series of demands to ensure a safe and secure return to more normal working in the NHS.

The focus is on safety of staff and patients, and ensuring that the NHS is properly resourced to meet the current and future demands placed on it. The Blueprint lists nine demands as the basis for negotiations with every NHS trust and employer.

- staff to be protected with sufficient suitable PPE.
- proper risk assessments to be carried out for all staff – (this requires a significant change in most trusts from the latest figures last week showing only a minority of BAME staff have been risk assessed). The assessments must have access to all information on every risk factor, including ethnicity, and proper training for the managers who will conduct them.
- unlimited access to testing and rapid results for both staff and patients/clients, so that resumed services can stay virus free for staff and patients.
- extension of the current Covid-19 pay arrangements so that staff get paid properly for all the hours they work
- employers to make sure that staff get a proper work/life balance (by recording and controlling excess hours, reviewing long and rotating shifts, enforcing working time regulations and encouraging staff to take rest breaks and annual leave).
- "rapid establishment of safe staffing levels" (making use of additional capacity from the Bring Back Staff initiative).
- staff to be informed about the support available to those most affected by the impact of the virus and encouraged to ask for help if they need it.
- Employers to facilitate and support access to childcare,
- A clear statement of intent that the contribution of all NHS staff in dealing with this pandemic will be reflected in future conversations about pay.

BAME staff

With heightened concern about the disproportionate impact of Covid-19 on BAME staff, UNISON has also set out what it would like to see in each workplace to minimise the risk, and several of these proposals overlap with the Blueprint.

They include:

- A review of any staff networks available to Black staff in the organisation – including those working for contractors, banks and agencies – and what could be done to support and strengthen what is available.
- Confirmation that staff not specifically invited to have an assessment can get one on request.
- Urgent review of how staff with underlying health conditions can be deployed safely
- Where staff are temporarily redeployed or reassigned, assurances should be given that they will suffer no detriment in terms of earnings, status or other terms and conditions.
- Review of channels available for Black staff to raise concerns and how UNISON can support and facilitate this.

The focus is on safety of staff and patients, and ensuring that the NHS is properly resourced to meet the current and future demands placed on it.

NHS Confed looks to unions for advice

Extensive guidance for NHS Trusts from their national body the NHS Confederation on risk assessments emphasises the important role to be played by the health unions. In particular the section on 'Support and advice,' which states:

"It will undoubtedly be necessary to supplement individual discussions with workers with the established collective representation processes in place within organisations.

… "Trade union colleagues and local partnership forums are an invaluable source of support to the organisation and their expertise and insights should be used in constructing local approaches to risk assessment.

"Employers can access a summary of principles from NHS trade unions on health and safety risk assessment and vulnerable workers (including BME staff groups) during COVID-19.

"Other networks such as those for black and minority ethnic (BME) or disabled staff will also be an important area of support and insight to organisations."

Tough questions on care homes death toll

Diane Peacock

As a relative of someone living in a care home, I was dreading the news that a resident or staff member had tested positive for Covid-19. It was obvious that nursing and/or residential care homes contained the largest enclosed communities of extremely vulnerable people in any healthcare setting outside acute hospital wards and hospices.

Weekly death registrations in care homes from week ending 13th March to week ending March 27th 2020 produced by the ONS/NRS published on the BBC website show overall death rates in care homes were below the five year national average, with no Covid related deaths reported on death certificates at that stage.

On March 19th 2020 the Government and the NHS had produced a directive that stated "unless required to be in hospital, patients must not remain in a NHS bed."

Acute and community hospitals were told they "must discharge all patients as soon as they are clinically safe to do so." Patients would be discharged home with or without healthcare support depending on need or to a suitable community bed.

Discharge from hospital, it was stated, should happen as soon as possible and was "expected to free up to at least 15,000 beds by Friday 27th March 2020, with discharge flows maintained after that."

On the 23rd March as the death toll in UK hospitals reached 335, the Prime Minister announced a national emergency. He said we needed to stay at home, protect our NHS and save lives. The same day an already operational 'Capacity Tracker' was extended to become a 'system wide' directive requiring all residential care homes, nursing/care homes and hospices to be fully using a Capacity Tracker by Wednesday 1st April 2020.

Since then care homes have been required, on a daily basis, to input bed occupancy and vacancies and staffing shortages, and confirm whether they were open or closed to admissions, including the number of Covid 19 residents.

Accelerate discharge

One primary aim of this single, centralised 'system' was to enable Clinical Commissioning Groups (CCGs) and local authorities (LAs) to accelerate the discharge from hospitals to care homes of those patients deemed suitable, and to deploy agency staff where care home workforce capacity was diminished by staff self-isolating or testing positive for Covid.

On 2nd April 2020, in tandem with the above, the Government issued Admission and Care of Residents during COVID-19 Incident in a Care Home that stated:

As part of the national effort, the care sector also plays a vital role in accepting patients as they are discharged from hospital – both because recuperation is better in non-acute settings, and because hospitals need to have enough beds to treat acutely sick patients. Residents may also be admitted to a care home from a home setting. Some of these patients may have COVID-19, whether symptomatic or asymptomatic. All of these patients can be safely cared for in a care home if this guidance is followed.

"From 28 April, all care home staff were eligible for tests but the DHSC capped the daily amount of care home tests at 30,000, to be shared between staff and residents.

"The government does not know how many NHS or care workers have been tested in total during the pandemic.

"Based just on tests carried out by the NHS, NHS England & NHS Improvement estimates that the number of NHS staff and the people they live with who were tested increased from 1,500 to 11,500 a day during April."

from National Audit Office report *Readying the NHS and adult social care in England for COVID-19,* June 12

By the week ending 3rd April deaths in care homes, including those with Covid on death certificates, had risen by over 1000 above average death numbers.

Peak mortality

Two weeks later on week ending 17th April 2020 ONS figures for deaths of care homes residents in England notified to CQC involving Covid reached their peak with 845 care home residents dying in hospital, 2,473 residents dying in care homes, 49 dying elsewhere and 260 where the place of occurrence of death was not stated.

On 28th April 'Community Care' UK reported CQC stating there had been over 4,000 deaths involving Covid-19 in care homes England in the past two weeks and that this was over four times the number recorded in residential and nursing homes up to that point.

Since 10th April an estimated 42% of total Covid deaths in my locality have been in care homes, this does not include care home residents that have also died of Covid in local hospitals or in undisclosed locations.

Given that by the week beginning 17th April the wider community had already been in lockdown for 26 days and some care homes' relatives and friends had been barred from visiting seven days or more earlier, Covid unless undiagnosed was already in some care homes.

The exponential rise in care home deaths was likely seeded by one or more of the following:

- **residents discharged from hospital with confirmed and untested Covid;**
- **new residents admitted from home some either with Covid or asymptomatic;**
- **by unprotected, untested staff exposed to the**

The dreadful loss of life through Covid is far too serious to be consigned to CCG Boards – or to a Public Inquiry that could take months to report.

virus from asymptomatic family members or when on public transport or doing essential shopping;

● or by agency staff, similarly exposed, but also moving from care home to care home for work where they could have contacted Covid.

All care home staff, including BAME staff at high risk of more serious infection should have been provided with enough appropriate PPE and routine testing to protect those they care for and themselves from Covid.

While the Government has now been pressured into taking action on PPE and testing in care homes, care home residents are still contracting – and dying disproportionately from – Covid-19.

Even as late as 8th June not all residents and staff in care homes had been tested.

With the cessation of local Joint Overview and Scrutiny Committees to oversee the impact of healthcare strategies at local levels, how can the best interests of the most vulnerable people in care homes be assured?

Too serious to trust to CCGs

The dreadful loss of life through Covid or suspected Covid is far too serious a matter to be consigned to CCG Boards or LA Cabinets that meet every other month – or to a Public Inquiry that could take months, if not years, to report.

No amount of questioning can bring back the thousands that have died in care homes but the more we know now, the better prepared we will be for a second surge or for another pandemic that may well emerge in the months and years to come.

Below are some of questions that need to be addressed at local and national levels.

■ How many patients in total have been discharged from the hospital into care homes since 19th March 2020?

■ How many care home residents were admitted to hospital for another condition and died in hospital of Covid since 1st April?

■ How many residents from care homes were admitted to hospital on or after 1st April with suspected or confirmed Covid, then died in hospital?

■ How many people who tested Covid-positive in hospital since 1st April were discharged to a care home?

■ How many asymptomatic patients were discharged untested from hospital for Covid into care homes and later developed symptoms of Covid since 1st April?

■ How many care home staff members, in what roles, were absent from work because of their own or a family member's suspected or confirmed Covid since 1st April?

■ How many staff, when tested in care homes, were found to have Covid?

■ How many agency staff have been deployed to cover for staff absence since 1st April?

■ How many of these agency staff were tested before entering a new care home?

■ What additional face-to-face, clinical support have care homes with suspected or confirmed Covid received during this period?

■ What is the justification for CCGs and local authorities continuing to transfer Covid-positive or suspected Covid patients to care homes?

■ To what extent did the differences in scale and financial status of care home provision locally and nationally impact on the equality of access to appropriate staffing, PPE and testing?

Huge numbers of excess deaths of care home residents graphically discredit the government's claim that they "tried to throw a protective ring around care homes".

Failures to minimise harm

The Government is ultimately responsible for failing to identify and prioritise the acute needs of this highly vulnerable sector in time to minimise avoidable harm.

Both the timing and huge numbers of excess deaths of care home residents in care homes and in hospitals graphically reveals and discredits the Government's claim that "right from the start" they "tried to throw a protective ring around care homes".

It is not acceptable for CCGs and local authorities to relinquish responsibility by saying that they were following government guidelines.

The Government, NHS bodies and local authorities, have a moral - if not legal - duty of care for vulnerable citizens.

Speeded up hospital building: a threat, not a promise

Any plan for a new hospital that is near the decision stage now must have been drawn up in the pre-Covid period: but now we hear Boris Johnson wants to push these through faster.

ROGER STEER, of Healthcare Audit Consultants, looks at how this could go wrong.

The Sunday Telegraph June 7 headlined "Boris Johnson speeds up hospital building to aid economy," an article by Edward Malnick, the chief political Editor and thus presumably carrying some authority:

It stated that the Prime Minister's plans also include:

"Measures to increase the "resilience" of the NHS before the winter, including with fast-tracked recruitment campaigns for doctors and nurses. …"

Also: "A major drive to reduce delays in the delivery of government projects, with a new team already examining the effect of cumbersome planning rules and 'endless consultations'. The team is studying possible reforms to the system of judicial reviews, resuming work begun in February, when Dominic Cummings, the Prime Minister's chief aide, warned that there must be "urgent action on the farce that judicial review has become."

It's all to happen "in the autumn" rather than overnight, so there is time to react to this. The stripping away of the checks and balances – which Johnson and Cummings regard as simply obstacles – could open the doors to a rash of ill-founded and half baked plans that squander billions and make systems worse than they are now.

The NHS has been spending hundreds of millions of pounds on management consultants, media consultants and "engagement" experts every year for at least twenty years in pursuit of "major reconfigurations" of one sort or another. A huge proportion of senior management time has been bound up in pursuing these schemes.

Unfortunately most of that time and effort by the NHS has been futile.

Modernising

In the past, new hospital building projects could be claimed to be modernising old hospitals and replacing them with more efficient new ones adopting new models of care, displacing more work back to GPs and community services. The argument was that the 'efficiencies' would cover the cost of the expensive PFI schemes and the annual payments they required.

Those projects that did go ahead have acted as test beds for this theory: but what actually happened time and again was that new hospitals turned out to be more expensive than expected to build, and the ongoing interest payments and servicing charges even more unaffordable.

Outsourcing of services to private contractors undermined the quality of catering and cleaning services, while in many new hospitals bed numbers were cut to such an extent that until the Covid crisis broke occupancy often exceeded the 90-95 per cent level.

Access was made worse, land sold off, and profits reaped. But the end result of reconfigurations actually delivered has often been counterproductive. PFI schemes in Bromley, Woolwich, the Royal London, Romford, and in other places, have saddled local health economies with debt, forced the hand of managers to cut staff and services, and left a weakened, overstretched service vulnerable to surges in activity and without sufficient staff and capacity when the NHS most needed it.

Not that this was inevitable. The consequences could have been foreseen and mitigated.

So Johnson's reported plans for infrastructure investment in the NHS have to be placed in context. The NHS has been starved of capital resources: so when substantial capital is finally made available it can seem like all the buses arrive at the same time. It has been called feast and famine, or boom and bust, although more often it's just famine and bust.

Cynical

The consequence of this is that it breeds a certain cynical opportunism amongst NHS managers. It is not the quality of the economic case that weighs in the final analysis, but being in the right place at the right time with a scheme that ticks the right political boxes.

Returning then to Johnson's attributed plans, what do we see?

Wishful thinking, "u" turns, dressing up of one thing with another to make it more palatable, and now counterproductive measures to ease the path to doing the wrong things more effectively. My biggest concern is the promise to halt delay in NHS investments, scrap planning rules and "endless" consultations, and to stop the "farce of judicial reviews".

It's clear that Boris wants to see new hospitals built: but like Blair and Brown, not necessarily the right hospital in the right place for the right price or with the support to ensure success: just enough new projects to fuel voter turnout prior to the next election.

By now the Tories were supposed to have published a revised capital funding regime for the NHS, replacing the discredited Private Finance Initiative policy that dominated NHS capital projects for 20 years.

Until the new regime is established, the old rules apply. This effectively means that the costs of new hospitals become a financial curse on local health economies. Investment, far from being a benefit, costs extra tens of millions of pounds of overhead costs each year that have to be found from revenue budgets.

As a result PFI hospitals have become black holes absorbing more and more resources and leaving the remaining services weakened, vulnerable and without resilience at times of greatest need.

People who scrutinize plans for new hospitals and point out the costs, risks and counterproductive proposals are decried for being obstacles to progress: but it needn't be this way.

Changes to the capital funding regime could be

The NHS has been starved of capital resources: so when substantial capital is finally made available it can seem like all the buses arrive at the same time.

introduced centrally to fund the additional revenue costs of capital schemes – as existed prior to the 1980s. However Treasury and Conservative chancellors much prefer to "starve the beast" and to punish local communities for pushing for increased public investment.

Since they still guard the financing rules, any extra investment will most likely continue to come with a large bill attached.

Johnson only sees as far as the next election and seems relaxed in promoting investment that will create havoc behind it.

Are we being too harsh? Let's look at the other measures being promoted: the first is to increase the "resilience" of the NHS before the winter by recruiting more doctors and nurses. Such positive measures are long on good intentions and hypocrisy, but short on practicability and sufficiency.

In reality the NHS continues to plan to cut NHS staffing levels (which is central to the most developed of the plans for new hospitals, in South West London, which would cut back on both staff and on acute beds).

The real intention is not to recruit additional trainees (the Tories cut numbers of medical training places post 2010) or to help local or international recruitment (badly affected by Brexit and additional immigration controls): both of these would be much more expensive to deliver.

Instead the aim is to deliver a smaller NHS, requiring fewer staff to deliver its services – starting with the new hospitals. That's why they want to reduce scrutiny, strip out consultation, and streamline decision making.

So we should be careful what we wish for, and cautious about the direction of the Johnson government, regardless of the claims made on his behalf by the Telegraph. It's likely to speed up the "transformation of the NHS" – but into a smaller, less resilient and overstretched service with fewer trained staff available to keep it going in fewer, more remote sites.

Campaigns have defended St Helier Hospital in Carshalton for years: – now plans for a new hospital in Sutton would downsize and downgrade it – halving numbers of acute beds

NAO report wakes up to extra PFI costs

John Lister

NHS Trusts operating from the 100+ buildings constructed under the Private Finance Initiative since 1997, and effectively leased from a private sector consortium, are likely to face difficulties negotiating changes to the shape and structure of the buildings to adapt to life with Covid-19.

The experience of staff in many trusts has been that PFI consortiums jealously guard "their" hospitals, objecting even to eye charts on the wall, and insisting even the smallest changes to the fabric of the building needs to be negotiated with, and delivered by the consortium – at extra cost.

That's just one of the many aspects of PFI that were not recognised – or disregarded – by ministers or by NHS trust negotiators at the time. Now the National Audit Office has produced a new report highlighting another neglected aspect of PFI – the costs and complications of negotiating the end of a PFI contract – including the question of what condition the building will be in, and whether the public body has to fork out further sums to buy the asset when the final payment has been made.

Conflict of interest

To anyone conscious of the conflict of interest at the heart of a "partnership" between the public sector and a profit-seeking consortium it will be no surprise that the NAO now concludes that:

"PFI providers have an incentive to limit expenditure on maintenance and rectification work in the final years of the contract as any savings can be used to pay out higher returns to investors."

No shit, Sherlock. It's only taken the NAO 28 years to issue this warning, after £57 billion of capital projects have been built in the UK, with much bigger repayments stretching on into the 2040s.

The NAO also belatedly note the relative bargaining power of the private sector in expiry negotiations.

While 328 public sector bodies have PFI contracts, 182 of them with just one apiece, the top six management companies control 45% of PFI contracts:

"This concentration allows the private sector to take a portfolio approach to expiry negotiations which risks putting the public sector at a disadvantage."

An even bigger disadvantage is that the public sector has allowed the management companies to take sole charge of the maintenance and repairs to buildings: 30% of those responding to the NAO survey do not even monitor annual maintenance spending.

Dissatisfied

Surprise, surprise: many of these companies have been taking full advantage, and failing to maintain buildings as required: almost half of the nine authorities that had taken ownership of PFI assets at the end of a contract were dissatisfied with the condition it had been left in.

The NAO warns that at least four years of preparatory negotiations will be needed to prepare for the end of PFI contracts, for which public bodies are not properly staffed, and a majority, in a triumph of hope over experience, are expecting to hire in management consultants.

The costs of this additional work has not been properly factored in to the overall cost of PFI contracts.

The Johnson government has disavowed PFI, but not addressed the substantial and still growing cost burden it imposes on NHS trusts: we can expect this NAO report to be quietly shelved.

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





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

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

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

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

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

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

Our supporters have already helped us to research and expose:

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

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

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

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

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

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

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

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

Every donation counts!

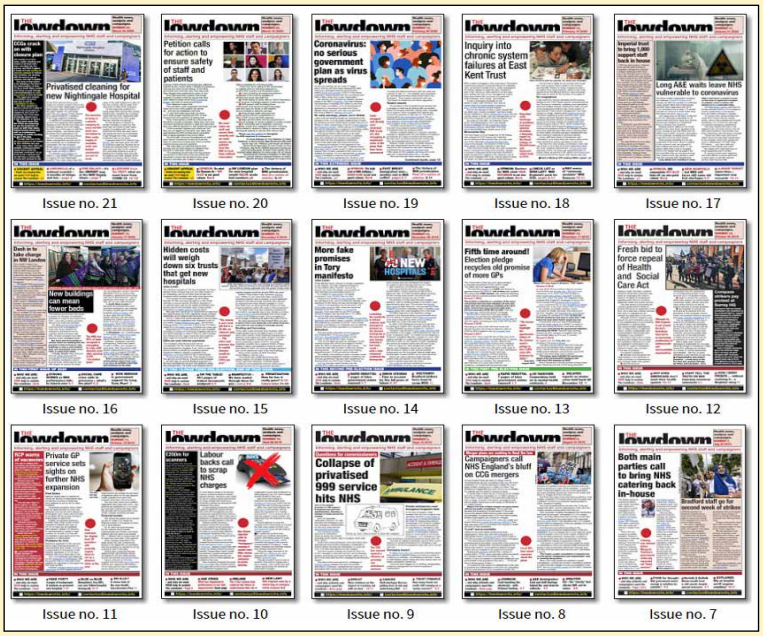
We know many readers are willing to make a contribution, but have not yet done so.

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

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

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

● **Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG**



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