THE lowdown

Health news, analysis and campaigns.
NUMBER 19, February 28 2020

Informing, alerting and empowering NHS staff and campaigners

# Coronavirus: no serious government plan as virus spreads

He almost certainly did not mean to trigger panic, but few will have been reassured by Matt Hancock's admission that the government's leaked worst case scenario of 80% of the British population being infected with the coronavirus and half a million dying from it was "reasonable."

Nor will they be comforted by Nadhim Zahawi's boast on the BBC's Question Time that ministers had allocated a miserable £45 million to the work of the Cobra committee, or by the lackadaisical approach to convening it by part-time Prime Minister Boris Johnson, who has now said that the virus is likely to "spread a bit more".

## No early warnings, please, we're British

Least of all will thinking people be impressed by the decision of No 10 to put public health at risk in future by blocking common sense plans by Matt Hancock for Britain to retain membership of the EU's Early Warning and Response System, which was key to combatting the bird flu outbreak and is helping to coordinate efforts throughout Europe to deal with the corona virus.

If the government's efforts have so far been underwhelming or counter-productive, it appears that cash-strapped and already over-stretched NHS trusts are also struggling to implement some of the plans that have been announced.

Following the lessons of the response to the swine flu pandemic ten years ago, hospital bosses have been told to create "pods" to allow people who suspect they've been exposed to the virus to be isolated for testing. The HSJ reports that uncapped capital is available to help fund such provision.

However the Sun highlighted the "isolation pod" at Lincoln County Hospital, which turned out to be "a small tent behind some bins with one chair and a phone to call 111." The facilities were described as "something that Bear Grylls would keep in his backpack". Trust bosses insisted the tent was "not meant for treatment and will be upgraded."

**Cash-strapped and already over-stretched NHS trusts are also struggling to implement some of the plans that have been announced**

## Targets missed

The problem is that hospital bosses already had a struggle on their hands dealing with yet another winter of increased demand, leaving many hospitals on or close to 100% occupied even without any coronavirus patients to take care of. The NHS is missing all its key performance targets. But of infected people ignore advice and go to hospital, long delays in overcrowded A&E departments and corridors could compound the problem.

The BMA has pointed out in early February that with more patients already facing delays in treatment than the previous winter,

"Stories of patient deaths on corridors, rammed emergency departments and cancellations of patient's procedures as a daily occurrence are becoming the new norm as doctors across the country say they are exhausted and run into the ground."

Shadow Health Secretary Jonathan Ashworth has also emphasised that the NHS capacity to respond to the coronavirus has been massively constrained by ten years of real terms cuts: "After years of Tory austerity, we know we've lost well over 15,000 beds since 2010," he said.

"We know that last week critical care bed

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## IN THIS EXTENDED ISSUE

# Worcestershire's hospitals still in a right royal mess

**John Lister**

Four years of "special measures" have apparently achieved little or nothing in the crisis-ridden Worcestershire Acute Hospitals Trust, whose two A&Es have been branded "inadequate" after an unannounced inspection by the Care Quality Commission in December.

This is an abrupt reversal from the previous CQC rating last September which as a result of an inspection in May declared that the troubled Trust's urgent and emergency care had improved from "inadequate" to "requires improvement."

This in itself was a surprise, following immediately after intervention by NHS Improvement, also in May, to implement a series of Enforcement Undertakings after finding the Trust was failing to operate efficiently, economically or effectively, and failing to ensure its services were safe. NHSI imposed a plan on the trust for it to take 'all reasonable steps' to recover its position.

It's not clear what changes the CQC might have detected that NHS Improvement had not seen.

However it is now obvious to all that the trust, centred on the PFI-funded Worcestershire Royal Hospital, lacks the necessary capacity to deal with winter pressures.

## 100 percent occupancy

The Trust's January Board meeting heard that "core occupancy" rates at both its Worcester Hospital and the Alexandra Hospital in Redditch had been running at 100%, and this resulted in notoriously long delays in handover times for emergency ambulances, with 797 delays of over an hour in December alone, up more than 50% from December 2018.

One patient died in December after being kept waiting for an hour in an ambulance outside Worcester's packed A&E. In November one patient was kept waiting 11 hours in an ambulance – so long he had to be switched to another ambulance when the original crew ended their shift.

His son counted 16 ambulances outside at the same time. Sadly such delays are far from new. In 2017 two patients died on trolleys in Worcester's A&E.

The CQC's latest report now also points to patients being treated in corridors "as standard" – a problem they noted back in 2017 – as well as overcrowding at the Alex.

However the Trust has also been the victim of absurd planning and commissioning decisions by the CCGs, which produced a completely misguided Sustainability and Transformation Plan for Herefordshire and Worcestershire in 2016.

## Prattling about prevention

Rather than address the long-standing capacity issues in Worcester and Hereford hospitals, the STP prattled on about putting "... prevention, self care and personal resilience at the heart of our plans", and reshaping the approach to prevention, "to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do".

The STP aimed to reduce spending on urgent care and emergency admissions, and elective treatment for 'non-life threatening' problems, diagnostics and medicines, in order to increase spending on Maternity care, Mental Health, elective treatment for life-threatening conditions (cancer, cardiac, etc.) and extended primary and community services (p17).

It proposed total closure of 202 community hospital beds and a net total of 55 acute beds, with all of these cuts in Worcestershire. It didn't make any sense then, and it's even more ridiculous now.

**Far from seeing any reduction in need for emergency care, the Worcestershire Trust has been inundated with increased numbers of patients.**

**Its performance summary for December points out that it had been expecting 5% more A&E attendances than last December "but had nearer 7%;" emergency admissions were also up over 8% on last year across both sites – with nearer 17% more at the WRH site – much higher than the predicted 5.3% increase.**

Performance in 4 hour emergency standard, ambulance handovers, 12 hour trolley waits, and number of hours patients spent on the ED corridor all deteriorated in December. Occupancy remained above 92% even though the Trust discharged more patients daily than predicted.

**December emergency admissions were up over 8% on last year across both sites – with nearer 17% more at the Worcester-shire Royal Hospital**

## Stress and sickness

Not surprisingly given the pressures, there has been an increase in absence due to stress/anxiety, worsening the staffing levels.

To compound the problem the chronically under-funded Trust is expecting to end the year with a deficit of "no more than £82.8m," and has not signed up to the "control total" of £64.4m deficit set by NHS Improvement. In 2018/19 it needed £70m of revenue support to support the deficit position.

**The Trust paid out over £31m on its PFI contract last year, bringing the total already paid for the £87m hospital and support services to over £420m, with another £370m still to pay until 2032.**

**At the end of 2018/19 its finances were propped up by £113m of current loans (up from £42m the previous year) and £159m of non-current loans.**

It's clear that the combination of poor planning, poor decision making by commissioners, and a serious lack of adequate services in the community, coupled with a chronic lack of financial resources have left the Trust in an impossible position, and that so-called "special measures" accompanied by occasional reprimands from the CQC and NHS Improvement have been of little help.

Worcestershire is not the only trust in this type of situation: sadly, given the recent election result, it seems no significant change of approach is likely to relieve the problem in the immediate future.

# Thank you – but we still need more support

A huge thank you to the supporter who has kindly donated a magnificent £5,000 towards this year's appeal to keep *The Lowdown* running without a pay wall and free to access for campaigners and union activists.

We have therefore always planned to fund the publication through donations from supporting organisations and individuals.

Having managed to raise enough money for our first year we now urgently need more to keep going.

**We urge union branches to send us a donation … but also please propose to your regional and national committees that they invite one of our editors to speak about the project and appeal for wider support.**

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

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 will be able to 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 would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at *contactus@lowdownnhs.info*

## In our first year, as promised, we:

- established a regular one-stop summary of key health and social care news and policy
- produced articles highlighting the strengths of the NHS as a model and its achievements
- maintained a consistent, evidence-based critique of all forms of privatisation
- published analysis of health policies and strategies, including the NHS Long Term Plan
- written explainer articles to promote wider understanding
- created a website that gives free access to the main content for all those wanting the facts
- pursued special investigations into key issues of concern, including those flagged up by supporters
- connected our content with campaigns and action, both locally and nationally.

# To go into a second year we need **YOUR HELP**

The Lowdown launched in February 2019 with our first pilot issue and a searchable website. Our initial funding came from substantial donations from trade unions and a generous individual.

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – **something that was not previously available to NHS supporters.**

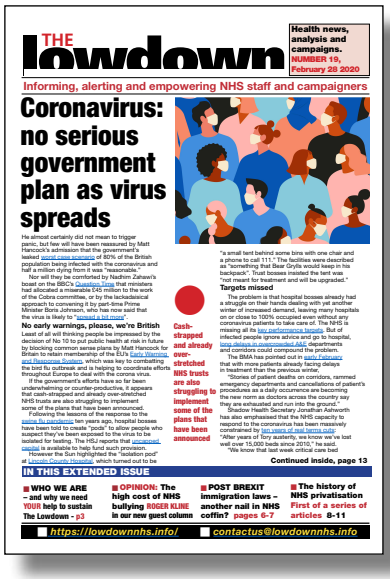
Our mission is to inform, explain, analyse and investigate issues and ensure that the founding principles of the NHS are upheld, in policy and practice.

Our editors and main contributors are **Paul Evans** of the NHS Support Federation and **Dr John Lister** (London Health Emergency, Keep Our NHS Public and Health Campaigns Together) who have almost 60 years combined experience between them as researchers and campaigners.

The aim of the project has been to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

To get it under way, we have worked hard to get the name established, build a core readership, and raise money where we can.

**We need to make the project self-sustaining, so we can pay new journalists to specialise, and undertake investigations and research that other organisations aren't able to take on.**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https://lowdownnhs.info/ contactus@lowdownnhs.info

We have had some success, and thank those individuals and organisations who have donated.

But seven months on, we need to step up our efforts to raise enough money to take us unto and through a second year, enough for us to be able to reach out and offer work to freelance journalists and, designers.

This autumn we will be making a fresh appeal to trade union branches, regions and national bodies – but also to individual readers.

We are providing this information free to all -- but it is far from free to produce.

**If you want up to date information, backed up by hard evidence, that helps campaign in defence of the NHS and strengthens the hand of union negotiators, please help us fund it.**

We urge those who can do to send us a one-off donation or take out a standing order.

**More details of this and suggested contributions are in the box below.**

Our commitment is to do all we can to ensure this new resource remains freely available to campaigners and activists.

Without your support this will not be possible.

# Privatisation round-up

## InHealth takes five NHS commissioners to court over procurement

InHealth, one of the leading diagnostics companies in England, is challenging five CCGs in the High Court over the award of a five-year contract worth £15.6 million to another private company, Healthshare Ltd.

The High Court was told by InHealth that, "The CCGs conducted the procurement - including the evaluation of tenders submitted by the claimant and Healthshare, unlawfully, in breach of its obligations [under procurement law]."

At the time of advertising the contract, InHealth was the incumbent provider. The five CCGS, Brent, Central London, Ealing, Hammersmith and Fulham, and West London, decided to combine several separate contracts into a single larger contract. This was put out to tender in 2019 and in August 2019 Healthshare was awarded preferred provider status.

InHealth claimed the CCGs failed to act transparently and to treat the bidders equally as prescribed by the tendering rules. InHealth has numerous contracts with NHS organisations around the country. The company has over 60 locations and employs around 2,200 staff.

Healthshare is a provider of integrated musculoskeletal (MSK) services to the NHS, and only entered the diagnostics market, through its acquisition of Global Diagnostics Ltd, in 2018. In the company's annual accounts, it states that it has 400 employees and services 250,000 NHS patients per year at over 86 clinical sites for 16 CCGs.

## Bestcare goes bust leaving staff unpaid and question mark over scans

A private provider of sonography services, Bestcare Diagnostics, has gone into voluntary liquidation, leaving several members of staff unpaid, according to the Manchester Evening News. An ongoing investigation into 1800 scans on NHS patients performed by the company is already taking place.

The company had provided sonography services across much of Greater Manchester, including in Rochdale, Wigan and Oldham, over the past four years.

However, in December 2019 Salford CCG as lead commissioner, stepped in to stop the Stockport-based company from practising due to 'concerns over the quality of the service provided'. The suspension came into force on 1 January 2020.

According to Salford CCG board papers the service provided by Bestcare Diagnostics was suspended for an initial period of six weeks, due to a number of concerns relating to Quality, Information Governance and Finance being identified.

Bestcare Diagnostics was a provider of sonography services, commissioned under 'Any Qualified Provider (AQP) – Non-Obstetric Ultrasound Services (NOUS)'.

Members of staff now claim they were not paid for work they did in December and some have also not been paid for November.

It is understood about a dozen former employees are owed money. They told the Manchester Evening News that they were given no notice that the company was to be wound up and the directors Sohail Ahmad Khan and his wife Rukhsana Tarannum, have not answered phone calls or emails.


*Bad losers: InHealth want to hold on to lucrative NHS contracts*

In 2019, Sohail Ahmad Khan stood down, and control passed to Rukhsana Tarannum. Dr Khan has since set up a new company, Supreme Care Health Solution, which is not registered with the CQC.

In 2018, Salford CCG was contacted by Coastal West Sussex CCG, which raised about its own concerns about Bestcare Diagnostics' work, also as part of a contract for non-obstetric ultrasound scans, from April 2017.

The CCG's concerns also revolved around quality and safety, complaints and incident investigations, and staff supervision.

At that time Salford CCG and the other Greater Manchester CCGs carried out their own investigations and did not find any significant concerns in their area.

The Sussex contract was suspended in September 2018 over what the CCG said were "quality issues". Then in spring 2019 new information came to light about the work carried out by two sonographers employed by Bestcare Diagnostics, who worked for the company between April and August 2018.

As a result of the new information, the CCG has reviewed 1,800 scans, including contacting the patients. The second stage of the review is now looking at whether any harm was caused to the patients.

**The failure of Medi 1 is the latest in a long line of failed companies involved in Sussex's non-emergency PTS.**

## GMB warns that patient transport services near "crisis point"

Medi 1, a provider of non-emergency patient transport services in Sussex, has gone into receivership, after getting into financial difficulties. This has left around 30 staff members unpaid and without work. The company was contracted to run non-emergency patient transport services to hospitals across Sussex.

The GMB union has warned that non-emergency patient services are now nearing "crisis point", and has called on health chiefs to bring the services in-house by contracting them to the NHS-run South Central Ambulance Service.

GMB regional organiser, Gary Palmer, is concerned that Medi 1 will just "re-present itself to the market in another form," and noted that: "The indecision of the CCGs in Sussex means I wouldn't be surprised if South Central Ambulance Service eventually has had enough."

He suggested that South Central Ambulance Service might pull out of future contracts because of a lack of leadership in Sussex. Mr Palmer called on Sussex health chiefs to offer a five-year patient transport

contract to South Central Ambulance Service.

The failure of Medi 1 is the latest in a long line of failed companies involved in Sussex's non-emergency PTS. During the time Coperforma had the contract, three private ambulance companies who were sub-contracted to do the work went bust - Docklands, VM Langfords and Thames Ambulance.

A Sussex Clinical Commissioning Groups spokeswoman said Sussex CCGs were "currently exploring procurement options" in relation to patient transport services.

## Clinical harm review underway after GP letters not sent

The NHS has launched a 'clinical harm review' to determine if any patients' have come to harm following the revelation that over 28,000 letters were not sent to GPs, following a mistake by the IT company, Cerner.

A leaked memo, seen by The Guardian, details an IT failure that meant 28,563 pieces of confidential medical correspondence to GPs from the Royal Free London group of hospitals were not sent between June 2019 last year and last month. The memo was sent 7 February 2020 by Caroline Clarke, the chief executive of the Royal Free London group of hospitals, which include Barnet and Chase Farm.

The letters should have been sent by doctors at Barnet and Chase Farm hospitals in north London to GPs after consultations with 22,144 patients. The letters summarise what patients discussed with their consultants about their diagnosis and treatment. A "technical error" on updates to the system run by Cerner has been blamed for the problem.

Rachel Power, the chief executive of the Patients Association, told the *Guardian*:

"Patients who have attended these two hospitals will now be very worried about whether their care might have been compromised by this IT bungle…..we know that sharing information to join up patient care is a major weakness of the NHS, so it is very disappointing to see that this failure took over six months to be detected."

Cerner UK, is the UK arm of the US company Cerner with headquarters in North Kansas City, Missouri. The company specialises in IT for healthcare companies. It operates in 35 countries worldwide.

Cerner UK reported that in November 2018, the Royal Free Hospital group, including Chase Farm and Barnet hospitals, launched the Cerner Millennium® electronic health record (EHR) across their three hospital sites.

*Talking the talk … but Cerner clearly can't walk the walk*

# NHS staffing crisis won't be solved soon

**Hannah Flynn**

It's no secret the Winter Crisis is being exacerbated by NHS staff shortages, despite years of the Conservative Government pledging to tackle the problem.

With nine out of ten hospital bosses saying the staffing shortages were endangering patients, the urgency of the situation can't be denied.

Figures released at the end of February showed there were 38,785 nurse vacancies in December 2019, down from nearly 43,500 in the previous quarter, and 8,734 medical vacancies across NHS hospitals.

These figures reflect the Government's own urgency in improving nursing recruitment, as outlined in its own Interim NHS People Plan published in June 2019.

An approaching retirement cliff is expected to make the problem worse, with 50% of practice nurses aged over 50. A survey by the NMC revealed that the majority (52%) of people leaving the nursing and midwifery register was due to retirement, while the next most common reason for leaving given by over a quarter (26%) was staffing levels.

While the Interim Plan outlines the importance of recruiting via nursing degree courses, it admits the lead time for this makes overseas recruitment essential in the short to medium term. However, with a global shortage of nurses expected to reach nine million by 2030 according to the WHO, it is unclear how successful this will be.

Data revealed by the NMC showed that while the number of nurses and midwives joining the UK register from countries outside of the EU has increased 8,877 in the past two years, the total number of midwives and nurses from the EU has dropped 4,989.

Government claims that the decision to scrap the student bursary in 2017 would increase higher education places for nursing students by 25% have not been realised, and total applications and acceptance onto nursing courses dropped in 2018.

A quarter of nursing students do not complete training, with many citing financial pressures.

Despite promises as far back as 2015 to recruit 5,000 more GPs by 2020, there were 1,000 fewer GPs last year than in 2015, and this situation is expected to worsen with a predicted loss of 1,869 fully qualified FTE GPs in 2024 than in 2019, according to one analysis.

Various attempts to introduce schemes such as the GP Retention Scheme, GP Career Plus, the Local GP Retention Fund, and the GP Health Service have not reversed this pattern, and one multi million pound programme to attract and retain GPs in Scotland acquired just 18.

While the finalised NHS People Plan was due to be published in the next couple of months, NHS England admit there is still no expected publication date for it.

If actions speak louder than words, this reveals depressing truths about Governmental priorities.

■ **Deterring overseas recruits -p6**

# Is the post-Brexit Immigration Plan another nail in the coffin for the NHS?

**This article has been written by Olivia Bridge who is a political correspondent for the Immigration Advice Service which has offices all across the UK and Ireland.**

The UK Government's promise to patch up the NHS and crack the whip on immigration control, coupled with the 'get Brexit done' trope, arguably became the golden ticket that awarded the Conservative Party its landslide majority in the 2019 general election.

Indeed, promises to fuel the NHS with wads of cash and fresh new recruits while simultaneously cranking the gates shut to EU labour by 2021 became the pledge of the decade. However, it is now quickly emerging that the two promises are simply incompatible as bit-by-bit, the Government's NHS promises and reams of pledges announced only a handful of months ago are now failing to materialise.

## Staff Shortages and Broken Promises

Prime Minister Boris Johnson's announcement to 'build forty new hospitals' in September last year has already transpired into a statistically-skewed myth: only 6 hospitals are scheduled for upgrades while 38 other hospitals will see some extra funding which will be sprinkled across the next decade.

The pledge to free up 50 million more GP appointments is evidently only possible with more physical hands on deck, yet the Home Office is already in debt to the GP workforce after it promised 5,000 new recruits in 2015 which not only never came to fruition but numbers actually fell. Subsequent changes to the Treasury in 2016 has since seen doctors slash their hours to save themselves from the savage pension tax later down the line.

With this in mind, the Government's intention to hire 6,000 more GPs barely ameliorates the gaping shortage it has helped to create and is causing to spiral still. Vacancies for doctors nationwide currently sit at 11,500 while the GP-to-patient ratio is considered the worst in 50 years.

*What a laugh! Priti Patel's immigration laws would have kept out her parents.*

**By the end of 2020 Freedom of Movement will be replaced with costly visas for EU citizens coming to work in the NHS**


Nursing is in an even worse position what with a stubborn 44,000 posts remaining unfilled – a figure which could climb to 70,000 in the next five years according to leaked government documents. Yet the Government's pre-election vow to recruit and train 50,000 nurses through a combative approach of overseas hires and homegrown apprenticeships actually translates to 31,500.

Around a third (18,500) who already work in the sector are supposedly set to be persuaded from leaving. The Government is certainly cutting it fine with this plan.

Of course, one approach could be found in recruiting homegrown talent: however, British students are more deterred than ever from taking up a medical degree. A lethal concoction of exhausting and unpaid work placements throughout the course, a £9,000 per year tuition fee and the end of nursing bursaries has seen a 30% decline in nursing applications since 2017.

UK universities are even declaring courses on radiography, mental health nursing, learning disability nursing, podiatry, prosthetics and orthotics to be 'at risk' of closure. Yet rather than resurrect bursaries, the Government wants to give students a maintenance grant between £5,000 to £8,000.

## Patient Care at Risk

Chronic understaffing is further having a domino impact on patient care and waiting lists which continue to soar. Most alarmingly, skin and bowel cancer sufferers are less likely to receive the potentially life-saving treatment that they urgently need in the face of backlogged queues reaching brand-new heights. As many as 1,100 patients could be missing out on that crucial early diagnosis every year.

And if that's not bad enough, fatigued and overworked staff is inevitably impacting performance including a spike of improper diagnoses and "inappropriate treatments", according to Dr Kailash Chand in Pulse Today. In the face of a depleting workforce, unqualified and untrained assistants are stepping in to perform nursing duties, which increases risk of patient harm by 21%. One survey shows 9 out of 10 NHS bosses fear for patient safety as a result of the shortages.

## Post-Brexit Immigration Rules

Clearly, a workable and adaptable immigration system is desperately needed to save the NHS from having


its issues spiral out of control. In this respect, Brexit appears to come in at a wholly unfortunate time as while the NHS attempts to compete for talent overseas, by the end of 2020 Freedom of Movement will be replaced with costly visas for EU citizens popping over the channel to come and work in the UK.

In a bid to mitigate the potential of even worse shortages that the NHS can't afford, the Home Office has been flirting with the idea of an NHS Visa which on the surface appears a step in the right direction: the visa cost is halved to £464, there is no cap on the number of allocated spaces and applicants should receive a verdict in a two-week turnaround.

However, to consider the NHS Visa as 'new' takes some serious logical contortion as its handful of benefits are almost identical to the existing immigration rules.

The current Shortage Occupation List (SOL) grants nurses, doctors and paramedics an exemption from the main chokepoints of the Tier 2 Work Visa rules – including a halved visa fee.

And that's not the only striking similarity: migrants of any vocation can opt to have their visa fast-tracked, but this usually comes at an additional fee.

It is currently unclear whether or not migrant NHS workers will be expected to pick up this bill – but someone has to cover the admin costs.

## The Immigration Health Surcharge

Either way, it certainly seems the spin doctors have been busy at work attempting to disguise the pre-existing Tier 2 route as something new – especially considering the NHS Visa could actually see migrant healthcare workers financially worse off and burdened with debt and that there is nothing on offer whatsoever for social care workers.

The Immigration Health Surcharge (IHS) has been at the heart of controversy for some time within the NHS as the charge dictates all migrants – no matter where they work – must pay thousands of pounds upfront alongside each visa application made.

This is in theory to pay towards any NHS treatments that they may need while living in the UK, but since its inception in 2015 leading NHS experts have being campaigning to abolish the fee for foreign NHS workers. They argue that inflicting the fee on staff who keep the sector from collapse is not only unethical but actively jeopardises recruitment drives.

However, the fee continues to rise without any waiver for those who opt to come and aid the UK's hospitals or GP surgeries – and the UK Government wants to hike it again from £400 per year to £625 per person per year.

One way to dilute the deterrent, according to Johnson at least, is to deduct the surcharge in regular instalments through NHS workers salary.

However, the Royal College of Nursing calls the charge "immoral and heartless" as no matter which way it's dressed up, EU citizens will lose the right to frictionless entry overnight by the end of this year and will wake up to eyewatering visa debts if they decide to come and work in the UK.

**No matter which way it's dressed up, EU citizens will lose the right to frictionless entry overnight by the end of this year and will wake up to eyewatering visa debts if they decide to come and work in the UK.**

Although NHS Trusts could pay the charge on behalf of prospective workers, the fee was theoretically levied to put money back in the NHS' purse – apparently to no avail as the latest NHS Bill offers an underwhelming budget increase.

The cash increase of £34 billion by 2024 is just a drop in the ocean towards the sum needed to expand resources, eradicate the NHS' workforce woes and its accelerating debt.

Arguably, the 'NHS Visa' appears nothing more than a cunning and successfully executed marketing ploy by the Conservatives. It fits well inside the 'Australian points-based immigration system' plot which, in line with everything else, has also been abandoned.

After all, there is no mention of the NHS Visa in the most recent publication of the rules, suggesting the idea was wheeled out purely to harvest votes.

If the NHS Visa does become a standalone route, the Home Office seriously needs to reassess the associated fees to be imposed on potential overseas healthcare staff.

As things stand its relentless pursuit of the most restrictive immigration plan in British history may very well serve to undermine the NHS, work against the best interests of the country and jeopardise the survival of backbone industries.

# A history of privatisation

## First of a series of articles by John Lister

In just over a year of publication, most issues of ***The Lowdown*** have carried reports on the continued inroads being made by the private sector into NHS budgets.

In May we attempted to draw a wider picture of the scale of private sector involvement, contrasting the real picture with exaggerated views that include occasional talk of "endgame," and claims that NHS England's Long Term Plan and other initiatives involving "Integrated Care Systems" – especially in the context of a possible post-Brexit trade deal with the US – are leading towards an American-style system, complete with charges for care and private insurance.

There were strong hints of this in Labour's heavy emphasis during the election campaign on leaked documents on the US trade talks, and frequent statements that "Our NHS is not for sale."

It's not clear that this approach, which sadly underplayed much of the content of a very good section of Labour's 2019 manifesto, was at all helpful, especially when it also appeared to ignore genuine and tangible local issues in many areas which should have given strong reasons for voters to fear a continuation of Conservative policy on the NHS.

A closer look at the origins of privatisation in the NHS under the Thatcher government in the 1980s and its subsequent evolution shows that far from wanting to buy up and privatise the whole of the NHS, the private sector has always been happiest when it can win contracts to provide specific packages of services that will be paid for from the public purse.


**Far from "selling off" these services, the NHS is "buying in" dubious quality services from private firms: far from flogging the NHS to "the highest bidder," services are entrusted to the lowest-priced, least reliable contractor.**


### No sale

Far from "selling off" these services, the NHS is "buying in" dubious quality services from private firms: far from flogging the NHS to "the highest bidder," services are entrusted to the lowest-priced, least reliable contractor. And nothing is being sold: once the contract comes to an end, the contractors do not own any of the NHS. They can only continue if they win a further contract.

Even where clinical services have been privatised, the result is not a "sale" to create anything like an American-style system, but a private company, on contract, delivering services previously delivered by NHS staff, but which remain free at point of use and funded from taxation, often even sporting the NHS logo on buildings and uniforms. No wonder some people don't recognise it as a problem.

It's a far cry from the wholesale privatisation of telecoms, water, electricity, gas, and the railways, which were literally sold off to shareholders and corporations, but it is a real problem.

Privatisation in health, in the political and economic context of Britain, almost 72 years after the establishment of the NHS, is the fragmentation and erosion of the public system, allowing the private sector to take a share of the public budget.

It is pernicious and destructive, but it needs to be fought in a way that shows the wider public what the issues really are.

So it's useful to understand the way privatisation began to take hold, after 40 years of stability and apparent consensus on the NHS and other welfare services were brought to an abrupt end with the election of the Thatcher government in 1979.


## Neoliberalism concealed

From the outset they argued that bringing in private providers to the NHS was a way of cutting costs, and tried to downplay the extent to which this was at the expense of staff and standards of care.

Of course the real agenda was what we now know as neoliberalism: minimising the scope of the public sector, holding down taxes on the rich and big business, and handing profitable contracts to their chiselling mates in the cleaning, catering and laundry industries.

As Hillingdon Health Emergency summed up in 1984:

> **"The important thing to realise is that privatisation is not being done to save money or to direct more finances towards patient care. The evidence indicates that it costs money rather than saves it and standards fall drastically. Privatisation is a political move to line contractors' pockets and destroy the power of organised labour."**

Indeed for Thatcher there was the added attraction that outsourcing low-paid but relatively well-organised hospital ancillary services undermined the trade union strength that had grown in the NHS during the 1970s and been a key factor in the prolonged series of strikes and protests over NHS pay in 1982.

The proposal to bring in compulsory competitive tendering to the NHS was first advocated by the Conservative Medical Society in a paper to the 1978 Tory conference.

After Thatcher won the 1979 election it began with a letter from the Department of Health and Social Security to all 192 district health authorities. It was largely ignored.

In 1982 a more strongly-worded draft circular was drawn up, but sidelined by the pay dispute. A heavily amended draft was reissued in February 1983, but it was not until after Thatcher's second election victory in 1983 that the key circular HC(83)18 was issued calling for Competitive Tendering in the Provision of Domestic, Catering and Laundry Services.

## Lobbyists' influence

This clearly reflected the impact of lobbyists from the industry: it states the government's belief that the use of private contractors "under carefully drawn and properly controlled contracts" could "often prove the most cost effective way of providing support services." It presses health authorities to "test the cost effectiveness of their … services by putting them out to tender (including in-house tenders)."

All District Health Authorities were given to the end of February 1984 to submit a timed programme for implementation, and told that they should not attempt to uphold any detailed requirements for staffing, or the length of time required for tasks.

Despite any other rhetoric, cheapness was the order of the day, not quality: "In no circumstances should a contractor not submitting the lowest tender be awarded the contract unless there are compelling reasons endorsed at district authority level …"

The Tory objective was clearly to ensure that private contractors secured as many contracts as possible, and this process was immediately branded as "privatisation" by the health unions of the day (NUPE, COHSE and NALGO, subsequently merged into UNISON, the GMBATU (now GMB) and ASTMS, now part of Unite) which began to step up their resistance.

To make matters worse, and enable even greater levels of exploitation of already low-paid workers, in the Autumn of 1982 (and long before EU-led TUPE regulations protected the terms and conditions of staff transferred from one employer to another) the Tories had rescinded the Fair Wages Resolution of 1946.

This which had ensured that contracts let by government departments must stipulate that contractors' staff should receive pay and conditions in keeping with the general levels in the trade.

Once this was removed he field was wide open to force through cuts in rates of pay and worse conditions along with loss of jobs and shorter hours.

**To enable even greater levels of exploitation of already low-paid workers, in the Autumn of 1982 the Tories rescinded the Fair Wages Resolution of 1946.**

## Work with campaigners

Unions soon began to see the need to work with campaigners to develop publicity and information that could convey to a wider and largely uninformed public (who were mainly concerned about cuts in services) that privatisation was not just a threat to the jobs and living standards of health workers, but also a major threat to the safety and quality of health care.

Some NHS managers were already reluctant to break up their established health care teams. Indeed ministers were forced to step in and force DHAs in Calderdale, South Cumbria and Cornwall to hand over laundry contracts to private firms. Management resistance was strengthened by early contract failures – a quality check in Cheltenham revealed 84% of hospital pillow cases and 73% of sheets laundered by Sunlight to be below the required standard.

So campaigners and the unions began to collate

**Continued overleaf, page 10**

## Privatisation ...continued from page 9

evidence of the performance and the impact of private contractors – to encourage DHAs to steer clear of failing firms, and increase the chances of threatened staff fighting back. In publicity from London Health Emergency the cockroach symbol was used as a visual reminder of plunging hygiene in hospitals.

By April of 1984, at the same time as the great Miners' Strike, the first major strike against privatisation had broken out at Barking Hospital in East London. As picketing continued and new disputes began around the country, the unions in London, together with GLC-backed campaigners London Health Emergency organised a 200-strong conference on Fighting NHS privatisation in County Hall in October 1984.

The message there was that the fight had to be waged not only against private contractors moving in, but also against drastic cuts in terms and conditions to win "in-house" tenders that would also undermine the quality of services.

In June 1984 domestics at Hammersmith Hospital had walked out on what became a 3-month strike against an in-house tender which replicated all the worst aspects of private contractors.

it proposed axing 40 jobs, cutting full time staff from 123 to just 15, cutting the pay for most of those remaining on part-time by 50%, and halving the hours for cleaning the hospital. The strikers were finally sacked in September, when the Special Health Authority voted to bring in private contractors Mediclean.

### Reputational damage

The relentless squeeze on standards also divided some of the Tories' own supporters: in the autumn of 1984 Gardner Merchant, a catering subsidiary of Tory-donating Trust House Forte, pulled out of tendering for any of the NHS catering contracts to avoid reputational damage.

"I have no desire to appear in the media accused of exploiting patients," said MD Gary Hawkes, "Just imagine what it would do to us if we were running the catering where there was a food poisoning epidemic like there has just been in [Stanley Royds Hospital in] Wakefield."

While Gardner Merchant stood down, up popped a new company, Spinneys, set up in 1983 to bid for NHS contracts, and immediately picking up contracts worth millions for catering, laundry, portering, security and gardening – without any experience in the NHS.

By the end of 1984 there was already a long and growing list of contract failures against some of the main players – including Crothalls (the firm that triggered the Barking Hospital strike by cutting hours of work and wages) who were fined in Croydon and Worthing and sacked in Maidstone for failing to meet standards and leaving nurses to do the cleaning; laundry firms Sunlight and Advance; Exclusive Health Care Services and Hospital Hygiene Services with failures in Leeds.

In some cases disputes against privatisation were victorious, and in other areas management themselves remained unconvinced of the merits of tendering.

By October 1984 two thirds of domestic catering and laundry contracts awarded had gone to private companies, but by July 1985 the pattern had changed dramatically, with the percentage of contracts won by private firms reduced to 40%.

It soon became apparent that the high profits the private contract firms at first expected would not would not to be forthcoming.

A number of private contractors pulled out of tendering for NHS domestic service contracts including Sunlight, Reckitts, OCS and Blue Arrow. The finance director of Blue Arrow declared "there is nobody making any money out of the National Health Service".

# Cockroaches angry at press reports

*Leaders of the Confederation of British Contract Cockroaches have strongly defended the Government's plans for privatisation.*

*Following an angry mass meeting of cockroaches in the grounds of Barking Hospital, staged to protest at 'biased' press coverage of cockroach activity on the wards, a statement was given to reporters stressing the contribution which these increasingly large insects are making to the cleaning efforts of the main contractors, Crothalls.*

*'Under previous governments, the private enterprise of Contract Cockroaches faced constant harassment..*

*'Now at last we are being given the chance in Barking to show what we can do when the bureaucratic red tape is cut loose. This government has finally given the small insect his head.*

*'The CBCC has for years argued that cockroaches have a role to play in cleaning up the morsels of rotting food and debris left behind by private contract cleaners, and at no extra cost to the taxpayer.*

*'Now, in close liaison with the scab workforce of Barking Hospital the kind of insect-human cooperation which should be a model for the NHS. We are not simply feeding off the NHS; we are making a real contribution.*

*'Our services are increasingly appreciated by the less squeamish patients, some doctors and most DHA members.'*

*Brushing aside recent newspaper reports of a terrified mother sheltering her baby against an infestation of cockroaches, the CBCC representative hit back angrily at 'sensationalist' coverage.*

**EXCLUSIVE!**
**By our own correspondent.**

C B C C

*Citing statements by consultant bacteriologist Dr Robertson, who sits on Redbridge DHA, the CBCC spokesinsect challenged reporters to 'name a single disease which our members could give a baby simply by crawling over it.'*

*Accusing critics and the mother in question of being 'politically motivated', the cockroach leader insisted:*

*'Our members were merely checking the baby and its bed for edible morsels of rotting food. This is routine procedure for our Barking night shift.'*

*He went on:*

*'Our members do a dirty and sometimes hazardous job: we are now the mainstays of the hospital cleaning operation.*

*'Those who ignorantly criticise our work are simply arguing for the return of the bad old days of in-house NHS cleaning, when cockroaches were subjected to all manner of ill-treatment and denied a livelihood.'*

Cockroach leaders have rejected claims that they are opposed to the privatisation of NHS catering services, with the resulting decline in standards of food provided.

'There is no denying that the lower quality of the scraps left around for our members will be a problem,' said a representative of the Confederation of British Contract Cockroaches. 'But against that we must set the fact that larger quantities of food with be discarded uneaten, and kitchen facilities will be less thoroughly cleaned. My members are prepared to exchange quantity for quality.

'The CBCC is still four-square behind privatisation and the contractors.'

'Cockroaches crawl on hospital babes'



### Moving the goalposts

With fewer contracts and lower profits than expected the private contractors began to lobby the government, urging ministers to "move the goalposts" to make it easier for private firms to win and retain ancillary contracts. On at least three occasions health authorities which attempted to award contracts in-house because they believed that the lowest tender by private contractor was unworkable were overruled by health ministers.

In March 1985 Bromley health authority had become so dissatisfied with the work done by Hospital Hygiene Services that they terminated their contract after six miserable months.

The option of dismissing unsatisfactory contractors had previously been argued by the contractors' own trades confederation the Contract Cleaners and Maintenance Association (CCMA) as one of the advantages of the competitive tendering method.

But as soon as it happened, Hospital Hygiene Services (whose directors included Tory MP Marcus Fox) immediately piled pressure on health minister Kenneth Clark, who within 24 hours authorised a telephone directive to all health authorities changing the rules in the contractors' favour.

Under the new instructions no health authority could decide to throw out a contractor, no matter how bad their performance, without prior ministry approval.

The delays this introduced into the process gave the company under threat the chance for a short period to throw extra resources into the contract to stave off the danger of dismissal, before reverting back to its unsatisfactory ways.

But even these changes were not enough for contractors. The beginning of 1986 brought news that Maidstone DHA had finally managed to break through the bureaucratic logjam and terminate its contract with Crothalls.

Once again out came a new set of directives from

**The fight had to be waged not only against private contractors moving in, but also against drastic cuts in terms and conditions to win "in-house" tenders that would also undermine the quality of services.**

NHS management Board Chairman Victor Paige and yet further restrictions on the dismissal of incompetent contractors, discouraging even the imposition of penalty payments for unsatisfactory work.

Health authorities were now required to refer any proposed contract cancellation to both the Regional Health Authority and to the DHSS before kicking out a firm.

They were prevented from asking contractors to specify performance rates of employees (opening the way for some of the more impossible workloads which had previously been the basis of artificially cheap private tenders.)

DHAs were also prevented from inquiring into the profit margins expected for particular contracts and from doing their own vetting of contract firms: they were told to rely instead on less discerning regional lists. Regions compiling approved lists were even told to avoid "intrusive" questions on the finance and competence of contract firms.

## Plan for compulsory contracting

The CCMA had drawn up an even more ambitious series of demands including the right for contractors to terminate contracts more easily, for health authorities rather than contractors to provide cleaning materials, and a reduction in the fines charged by health authorities when contractors failed to carry out their work.

At the end of 1986 CCMA Secretary-General John Hall even argued that the government should abandon compulsory competitive tendering … and switch to a policy of compulsory contracting out!

However one of the reasons why contractors were having problems was that health authorities feared loss of direct management control of the crucial ancillary services, and were less than impressed with the performance of the contractors already at work in the NHS.

In this context is doubtful whether the Paige letter, making it much more difficult to ditch an incompetent contractor, made it easier for the firms concerned to win contracts.

By September 1986, the target date for completion of the tendering process, despite all of the efforts of ministers to force through private contracts the National Audit Office found that only 68% of the services by value had been put out to tender. Some health authorities, notably in Wales and Scotland had simply refused. The private sector had won just 18% of the 946 contracts that had been awarded. By February 1987 according to NUPE, 79% of contracts awarded had gone in-house with only 21% awarded to private contractors.

**The contractors drew up an even more ambitious series of demands … and even argued that the government should *abandon* compulsory competitive tendering … and switch to a policy of compulsory contracting out**

## Plunging standards

But many in-house tenders were also under-cutting even the contractors, and further undermining the quality of patient care: contracting out – whether or not the private sector won the contract – was leading to a disastrous drop in hygiene standards that created ideal conditions for the spread of a new 'superbug' MRSA.

By the winter of 1987, as a massive new round of spending cuts pushed waiting list scandals onto the front pages of even staunch Tory newspapers, significant damage had already been done to the infrastructure of support services in what were increasingly overcrowded hospitals.

A 1988 round-up of privatisation across London's NHS compiled by London Health Emergency for the Association of London Authorities revealed the scale of the problem.

Many of these services in England have been repeatedly subjected to competitive tendering every few years since 1983, although the Welsh and Scottish governments since devolution have brought support services back in house.

Even now some English hospital trusts have not learned the lessons of these failures. One example is as Luton & Dunstable University Hospital FT, which failed to secure adequate standards in a private contract in 2015, but is again showing that they have learned nothing from almost four decades of failure of competitive tendering, and offering a larger, less well-funded 10-year contract for cleaning and catering, while excluding any discussion of an in-house bid.

But with tendering in full flow, 1988 brought a new dimension to privatisation as the Thatcher government turned its attention to what we now call social care, and embraced a report proposing a massive privatisation of care for older patients that is still with us in England today.

**Part 2 of this series will pick up the story from there.**

# A dying shame: Marmot throws down the gauntlet on austerity and inequality

**Alan Taman**

Austerity kills and its legacy will keep killing – unless government makes health and well-being the heart of its policy. That is one of the stark and uncompromising conclusions to be made from Michael Marmot's Review, Health Equity in England: The Marmot Review 10 Years On, published earlier this week.

The original Marmot Review, published 10 years ago, was hardly happy reading: the gap in life expectancy between the richest and poorest and between least and most deprived regions was widening then. But at least we could all expect to live longer than our parents did, on average.

Not any more: a female child born in the poorest areas of England can now expect to live a shorter life than her mother, while life expectancy continues to increase for the most well off – but even that is visibly slowing, year on year.

**The life expectancy gap on average between the richest and poorest in England is now 9.5 years for men and 7.7 years for women.**

The 2020 Review points out that the poorest areas have been the hardest hit since 2010, with cuts in funding to promote good health, improve the environment, and make working lives or surviving on benefits better for the least advantaged disproportionately affected.

The number of years people can expect to spend in ill health also follows a social gradient, with the poorest not only leading shorter lives but spending more of that shorter life in ill health.

They live less and suffer more for it.

As Marmot himself put it:

"Not just increasing inequalities but actual decline in life expectancy. That's not supposed to happen. We've got used to the fact that life expectancy and health improves year on year. That's what we've come to expect, but it's not happening any more.

"This is a health crisis. And if you accept the argument that health is telling us something fundamental about the nature of society, it's a social crisis."

## England is faltering.

Marmot lays the blame firmly on the social and economic causes for ill health – there is no suggestion that this is down to 'bad' individual behaviours (though yes, they of course make a difference; just nowhere near the biggest).

The Review also gives clear areas for stopping the blight of health inequality.

Giving every child the best possible start, enabling children and young people to achieve their best and have control, creating fair employment and good work for all, ensuring a healthy standard of living, and creating and developing healthy and sustainable places to live are outlined after carefully describing the underlying evidence.

The effects of climate change are linked to ill health for the first time, and addressing climate change is an explicit point of action.

But perhaps the most encouraging part of the Review is its boldest: Marmot and his team call on the Prime Minister to make addressing health inequality a key concern for government, and put well-being – not fiscal growth – at the heart of government policy.

**"We've got used to the fact that life expectancy and health improves year on year. That's what we've come to expect … but it's not happening any more."**

But we've been here before. The first Marmot Review was published in 2010, coinciding with the end of the New Labour government, the launch of the Con-Dem coalition and the austerity which followed made matters far worse.

Will we, in 10 more years, look back on 'Marmot 2020' and ruefully conclude government has, yet again, done nothing to stop things becoming even worse? Marmot did not hesitate, during the launch conference of the Review, to lay his cards on the table:

"We have to make sure that we change the agenda, we take the action, that we don't sit back and say "how will it come out?"

"We convince politicians, the policy makers, as well as our communities, that we are serving in the cause of social justice and health equity. And what greater cause could there be than that?"

This is a far and I would say welcome cry from the 'detached' academic stance of taking no political action. Marmot is saying, as he more than anyone is surely entitled to say and able to judge, 'We must change this'.

**Alan Taman is Communications Manager for Doctors for the NHS and is completing a PhD on the public perceptions of health inequality solutions and policy engagement at Birmingham City University.**

# No serious plan to deal with coronavirus

**continued from front page**

occupancy was running at over 80%. There are serious questions about whether the NHS has the resources, the staff and the capacity to provide the care that's needed should this seriously escalate."

The latest planning guidance from NHS England, calling for an end to any further bed closures, tells trusts that the crisis provision for this winter should become the new norm:

"The default operational assumption is that the peak of open bed capacity achieved through the winter of 2019/20 will be at least maintained through 2020/21, including the 3,000 increase from October 2019 already planned for."

**But clearly this takes no account of a pandemic that is estimated could infect up to 4% of the population – over 2 million people.**

On Question Time *Big Issue* founder John Bird argued that "This is not just a health crisis, it's a social crisis," he said, arguing the Government needs to round up every available health facility and resource it has to tackle the 'war'. Bird, apparently unaware of just how small the British private hospital sector is, with just over 2,500 acute beds (many of them staffed by NHS staff working additional hours) called for "The nationalisation of the health service in the truest sense of the word for a particular time in order to deal with this pandemic."

In the US, the former chief of the Center for Disease Control and Prevention Dr Tom Frieden has warned that it is "inevitable" that the coronavirus becomes a pandemic: "The last moderately severe influenza pandemics were in 1957 and 1968; each killed more than a million people around the world. Although we are far more prepared than in the past, we are also far more interconnected, and many more people today have chronic health problems that make viral infections particularly dangerous."

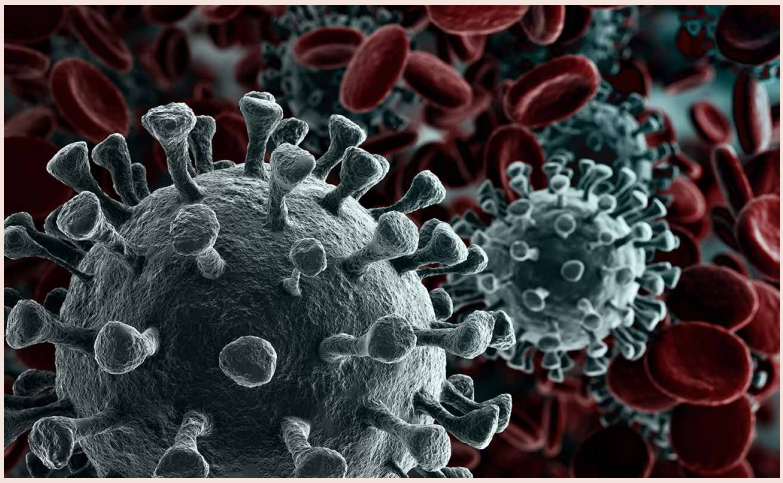
A US, where only 500 people so far have been tested, and punitive charges are putting off people with limited insurance from seeking tests, academic simulation of a coronavirus pandemic showed a world wide death toll of around 65 million, until 80–90% of the global population had been exposed, after 18 months: the spread was eventually "slowed due to the decreasing number of susceptible people. The organisers insist that this was a theoretical scenario, not a prediction.

However the state of Washington in the US North West has declared a state of emergency after a patient in their fifties died, and two more cases were discovered. Researchers warned the virus may have been spreading unfettered for weeks and infected 1,500 people.

## "Battle plan"

So how will the NHS cope, and how well prepared is the government? Boris Johnson's so-called "battle plan" includes trying to bring recently-retired doctors and nurses to return to work in the NHS (although older age groups are more vulnerable to the virus, and many of those who have recently retired have left early as a result of stress and burn-out).

If the coronavirus outbreak worsens, ministers are saying emergency powers could be employed to close schools and ban large events, and Matt Hancock has refused to rule out locking down whole cities, along the lines of the Chinese government's isolation of Wuhan.



*If you see one of these anywhere, kill it!*

It's clear that the virus is now beginning to spread: and the question of how NHS staff are led, managed and treated is important, after the recent NHS staff survey highlighted widespread bullying, with less than a third of staff believing there enough staff in their organisation for them to do their jobs properly and 40% reporting work related stress (See Roger Kline's Opinion column, back page).

Staff unions and NHS employers have issued guidance on how best to respond should any patients with suspected Covid-19 require a diagnosis or treatment. The aim is to ensure staff know exactly what to do with individuals who're concerned they have the virus and how to treat infected patients, with minimal risk to themselves.

It advises NHS trusts to ensure that all staff – including those employed by contractors – must know how to lower their infection risk. For example, regular handwashing and using – and disposing of – tissues.

**For many of the 1 million staff working in social care, the vast number of them for private employers on far worse conditions that the NHS, and many on zero hours contracts at minimum wage, the question is whether they get any sick pay at all.**

## Contractors

But of course there are problems where management – or private contractors who have refused to grant staff equivalent terms and conditions equivalent to the NHS national Agenda for Change provisions – fail to address key issues.

For example ensuring that staff who are required to miss time from work are able to survive on what sick pay they receive. The guidance says that where staff are required to self-isolate, it is vital that employers clearly communicate pay arrangements during this period of absence, and that

"Where staff are being paid under contractual sick pay, any absence should be treated as an absence related to compliance with national infection control guidance and should not count towards any sickness absence policy triggers."

Meanwhile for many of the 1 million staff working in social care, the vast number of them for private employers on far worse conditions that the NHS, and many on zero hours contracts at minimum wage, the question is whether they get any sick pay at all.

Matt Hancock has tried unconvincingly to suggest that the vicious bureaucrats of the Department of Work and Pensions will provide support for self-employed and casual workers who self-isolate for medical reasons, but their dismal track record on Universal Credit gives little reason to trust them to get this right.

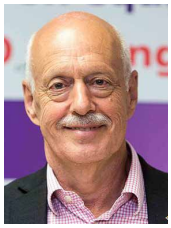
The GMB union has flagged up this issue – which seems not to have been even considered by ministers:

"Workers in the so-called gig economy, or on zero hours contracts, are left abandoned and penniless if they have to self-isolate. Once again the bogus self-employment model is screwing over the disadvantaged.

"GMB is calling on all employers - regardless of the contract– to do the right thing and pay their workers if they have to take time off due to the global health crisis."

**This is a new feature in *The Lowdown*, in which we invite observers and campaigners to air their own views on an NHS-related topic of their choice**

# The high cost of NHS bullying

**Roger Kline**

**We know from research that managing healthcare staff with respect and compassion correlates with improved patient satisfaction, infection and mortality rates, Care Quality Commission (CQC) ratings and financial performance as well as lower turnover and absenteeism.**

We know that bullying in healthcare undermines patient care and safety making staff less willing to admit mistakes, report concerns and work in effective teams – as well as costing the NHS at least £2.3 billion a year.

We know that discrimination against NHS staff (especially race discrimination) impacts adversely on patient experience and care.

So anyone who cares about the NHS should listen carefully to the 500,000 staff responses to the 2019 NHS staff survey:

- **12.3% staff (almost one in eight) experiencing bullying and harassment from managers and 19.0% (almost one in five) from colleagues.**
- **Just 48.0% say they feel their organisation values their work**
- **Twice as many black and minority ethnic staff as white staff do not believe there are equal opportunities for career progression or promotion**
- **Under one third of staff think there enough staff in their organisation for them to do their jobs properly and three quarters report unrealistic time pressures.**
- **Almost a third of staff (31.5%) do not believe they are able to deliver care at the level they aspire to, and 40% report work related stress.**

The survey gives a sense. These symptoms of the workload, vacancy and funding pressures the NHS faces are the culmination of a decade of real terms spending cuts at the very time when healthcare needs are rising.

Faced with such pressures the evidence that treating staff better improves patient care (a no brainer really) and reduces turnover, stress, and staff ill health is even more powerful.

## Plan to do better

That research has finally started to feed through into some local NHS employer practices and now into NHS Improvement's Interim People Plan which explicitly seeks to reverse some of the more common poor work practices in the NHS.

But there is a major potential problem. NHS funding became a major election theme so more money for staffing and for capital infrastructure was promised.

But the long arm of Dominic Cummings is already risking a reversion to the worst sort of Ministerial bullying in an attempt to blame NHS managers for the difficulties in delivering the mythical 40 new hospitals and the 50,000 new nurses contained in his election manifesto.

*Health Service Journal* (HSJ reported in February that "senior government officials are challenging NHS England's plans for boosting retention to deliver the prime minister's target of 50,000 more nurses."

A leaked email from the Department of Health and Social Care to NHS England set out "particular concerns" about the "retention delivery plan" for the target. The DHSC has ramped up its involvement in the NHS' staffing plans and says ministers would expect a "clearer model of change in the delivery plan" on "culture".

**As Dominic Cummings gets drawn into the stand-off, the epidemic of bullying he has already triggered across Whitehall will risk cascading down to Trusts.**

## Feeling the heat on fake 40

A similar pattern of pressure from No.10 can be seen on the mythical 40 new hospitals, with NHS England/Improvement's head of estates telling HSJ "we're already feeling the heat from the administration to ensure we're running at pace."

Some may remember the last time Ministers pushed inappropriate national NHS targets with the creation of Foundation Trusts.

The impact on patients was a bullying culture – led by Ministers – that led to disasters like Mid Staffs. The subsequent Francis inquiry blamed the Mid Staffordshire failings on an institutional culture which put the 'business of the system ahead of patients'.

The Public Inquiry was told there was a "pervasive culture of fear in the NHS and certain elements of the Department for Health. The NHS has developed a widespread culture more of fear and compliance, than of learning, innovation and enthusiastic participation in improvement."

The Election Manifesto promised impossible targets. These will inevitably collide with the refreshingly positive approach to staff culture in the NHS People Plan.

**You don't have to like every comma in the Plan to recognise it is potentially a major step forward.**

But as Cummings gets drawn into the stand-off, the epidemic of bullying he has already triggered across Whitehall will risk cascading down to Trusts. If that happens staff survey data will deteriorate even further, bullying and turnover will increase, more staff will burn out or walk away – and care will deteriorate.

If and when the DH seeks to counterpose ministers' fantasy recruitment and building programme to real efforts to retain and treat staff better, the rest of us (staff and patients) might just join them in telling No.10 to back off.

**Roger Kline is Research Fellow at Middlesex University Business School**