THE lowdown

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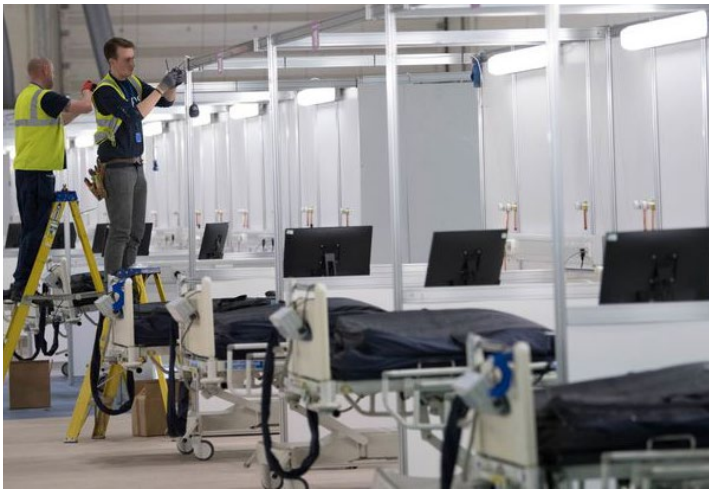
Informing, alerting and empowering NHS staff and campaigners

Major plans for London's post Covid NHS hatched behind the lockdown



London Nightingale closed for lack of staff: with thousands of empty NHS beds, NHSE still plans to use private hospitals

John Lister

Debates over relaxing the lockdown and whether or not the peak of the Covid-19 crisis may now be behind us have run alongside fleeting glimpses of the surreptitious plans being laid to exploit the continued lockdown on NHS public meetings and spring a succession of unpleasant surprises on the NHS as soon as any recovery period begins.

As we go to press The Lowdown has seen a letter from NHS England's London Regional Director Sir David Sloman, sent out internally on April 29 but not published, requiring Integrated Care System (ICS) Chairs and Senior Responsible Officers to take "urgent action" on system plans for London that "fundamentally change the way we deliver health and care."

Each ICS is ordered to supply a "revised ICS plan" by Monday May 11. The letter spells out a 12-point list of issues on which bureaucrats in each area are supposed to devise new policy, on the hoof, for a "Recovery Board" meeting on May 13.

12-day turn-round

Even if the country was not on lockdown, this 12-day turn-round period for proposals on fundamental changes for a New Health and Care system for London, to be in place by November 2021, would indicate a complete disregard for any serious consultation or discussion.

But it's clear from the way this is being done that any notion of public engagement or accountability is a very low priority afterthought.

The accompanying Powerpoint presentation entitled 'Journey to a New Health and Care System' states that over the next 12-15 months they hope to keep public engagement to a bare minimum: "Include public and stakeholders in the process within the constraints of an emergency".

NHS England is looking to use private hospitals to clear the waiting list that has grown so rapidly with months of cancelled elective operations

It proposes mergers of admin and clinical support services, implying job losses, and a focus on getting people out of hospital as soon as possible – but with no details on how they should be supported after that.

Chances of seeing a health professional would be increasingly small, as primary care and outpatients seem set to become "virtual by default".

Snail's pace

Perhaps just as worrying is that while pushing through a whistle-stop process of planning, NHS England is only planning a snail's pace return to previous levels of elective surgery: "a plan to restart routine elective care as outlined in the national guidance within 12 months".

The Powerpoint slides also make clear NHS England is looking to use private hospitals to clear the waiting list that has grown so rapidly with months of cancelled elective operations.

There is no discussion of where the staff are to be found to carry out this additional work, or the added costs of prolonging the NHS block-booking of private beds (which have only been partially used during the Covid crisis, while tens of thousands of NHS beds have remained empty).

There is equally little if any consideration of mental health, community services, or the specific problems of social and racial inequalities.

Conspicuously as with every NHS reorganisation there is no attempt whatever to critically assess previous plans and proposals, and the extent to

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Post Covid plans

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which so many plans since Sustainability and Transformation Plans in 2016 have disastrously focused on cost-cutting, reconfiguration and cutbacks in hospital services and capacity – and left the NHS in the capital and throughout England desperately ill-prepared, under-staffed and ill-equipped to deal with a pandemic of any scale.

Clearly the plan is to use jaunty new rhetoric of a "post-Covid NHS" to distract attention while NHS bosses covertly consolidate changes that have been accepted with minimal discussion to deal with the Covid crisis, but which would be controversial as a permanent arrangement.

Catalogue innovations

The London Powerpoint makes this clear under the heading of 'Innovation'; they see the task as being to: "Catalogue the innovations made," and to "determine those to be retained; evaluate; plan for widespread adoption (e.g., virtual primary care, outpatients, remote diagnostics, new approaches to triage, workforce models, use of volunteers, remote working, pace and urgency to decision making, financial models)".

NHS England bosses are keen to exploit the situation to short circuit any consultation, "stepping up the new borough based ICPs" – which are not public bodies and lack any statutory legitimacy – along with "streamlined decision-making": in other words even less public consultation on anything.

No reversal without approval

While each ICS is required to catalogue "changes made to date," they are also warned that "reversal requires London approval".

So as the NHS eventually emerges from its biggest-ever crisis, campaigners will need to be proactive in preventing NHS England bosses steering it straight into a new system – designed without evaluation of the impact of the crisis measures or consultation with local communities, and without any public accountability.

Those who don't share NHS England's vision of the brave new post Covid NHS will need to "stay alert" and "protect our NHS".

More covert post Covid plans

The Lowdown has previously highlighted the continued work of bureaucrats behind the scenes in South West London to drive through a controversial hospital reconfiguration that could halve numbers of acute beds – while all public meetings and discussions are paused.

These plans reach into Surrey, where the HSJ has now also revealed the newly merged Surrey Heartlands CCG starts life with an inherited deficit of £62m – confirming that the much vaunted recent cancellation of £13.4 billion of NHS debts related only to loans run up by trusts, and that the post-Covid financial regime seems set to be as tight as before.

Lancs and Cumbria laboratories at risk

Lockdown used to hide merger plan

Unite has uncovered plans being progressed "under the radar" in Lancashire and South Cumbria, to drive through the merger of four NHS hospital laboratories serving a population of 500,000 people (Blackburn, Blackpool, Lancaster and Preston) into a single hub in Lancaster, and fuse pathology services into "one single hosted organisation" covering Lancashire and South Cumbria.

Stab in the back

Unite's regional officer Keith Hutson said: "NHS bosses are using the pandemic to reintroduce this flawed plan under the radar which will increase the times for processing samples. Our members who have given their all during this crisis feel the deliberate lack of consultation is a stab in the back.

"We are going to involve the region's MPs in this campaign, including The Speaker Sir Lindsay Hoyle, MP for Chorley, as, in the long-term, we fear that any super lab could be ripe for being sold off to a profit-hungry healthcare company.

Unite's challenge is in response to a May 6 letter to staff from the Managing Director of Lancashire and South Cumbria Pathology Collaborative, Mark Hindle, which after going through the motions of thanking staff for all their "hard work and service" goes on to focus on the "day job":

"as we start to see hospitals trying to get back to normal service myself and colleagues are still working to develop the Outline Business Case (OBC), that the Board will use to help them determine our future direction. … we have a large capital allocation available to us to provide new buildings for our services as we move forward once the Business Case is agreed."

It appears that the Business Case will put forward three possible models:

- A hub and spoke model (generally referred to as hub at Lancaster and small local laboratories (ESLs) to undertake urgent and work required at the hospital sites)
- A distributed hub where disciplines are co-located within existing estate supported by ESLs at hospital sites
- A do minimum option

Merger plans for a super lab at Lancaster, covering the areas of five NHS trusts, were rejected last year – because it would make the service too remote

Only option

But the next paragraph makes it clear that only one option is really being proposed as the way forward:

"The other main topic of conversation from the Board was how we bring our Pathology services in Lancashire and South Cumbria together into one hosted organisation in the future."

Unite points out that merger plans for a super lab at Lancaster, covering the areas of five NHS trusts, were rejected last year – because it would make the service too remote from local GPs and hospitals, and increase processing times from the current 24 to-48 hours.

If you like what you see in The Lowdown, please donate to help keep it going!

A pandemic of NHS privatisation

Sylvia Davidson

Out of sight of public scrutiny, dozens of private companies have been awarded contracts to carry out work for the NHS, much of which could have been carried out by the NHS. These contracts have covered the Nightingale Hospitals, testing centres, laboratories, PPE procurement and staff recruitment.

Using procurement guidance issued in January 2020 , companies have been awarded contracts through a fast-track process that has lacked transparency with no publication of the contract and no competitive tender.

The details, including how much the contracts are worth have yet to be made public; there are new rules stating that the departments must publish the contract award notice within 30 days of its agreement, but almost none have done so, according to the Financial Times in early May.

The companies awarded contracts include some of the largest accountancy and outsourcing firms in the country, including Deloitte, KPMG, Serco and Capita. There has been little or no scrutiny and it is questionable whether some of the companies would have been appointed at all under normal circumstances if a thorough investigation had been made of whether they are qualified for the job.

A good example is Serco and G4S, both of which are reportedly in-line to be awarded a contract for contact tracing and already have contracts for testing centres. In 2019, Serco was fined £19.2m and had to pay £3.7 million in costs by the Serious Fraud Office over an electronic tagging scandal. Both Serco and G4S were accused of charging the government for electronically monitoring people who were either dead, in jail, or had left the country.

Within healthcare, Serco is best known for the scandal of the out-of-hours contract in Cornwall, which included falsifying data and not employing enough qualified staff.

Deloitte cashes in

A major winner of this rush to outsource work has been the giant accountancy firm, Deloitte, which was recruited in March by the Department of Health and Social Care to help create a network of up to 50 virus testing centres around the UK and by the Cabinet Office to assist with the procurement of personal protective equipment (PPE) for frontline NHS staff.

Deloitte then appointed several other companies to run the testing centres at a regional level, including Serco, G4S, Mitie, and Sodexo, and the pharmacy chain Boots.

Reports are already coming in of problems at these centres. The Guardian wrote of numerous reports of long queues at some facilities of up to five hours, with motorists stuck in their cars for hours, forbidden from opening windows and unable to use toilets or find water, workers with appointments turned away because of delays, leaking test vials, wrongly labelled samples, and lost test results at Nottingham and Wembley.

The sites are operated by companies, such as Sodexo and Serco, but Deloitte is managing logistics and data, including booking tests, getting samples to the labs and communicating the results. There are reports of long waits for test results and people having to email numerous times to chase their results.

The Cabinet Office has also reportedly compounded the confusion in the largely privatised NHS Supply Chain and its handling of PPE procurement by bringing in Deloitte to run UK sourcing efforts. It's not clear if they were responsible for the notorious shipment of gowns from Turkey which has now been found to fail safety standards.

There have been numerous stories of UK manufacturers of PPE being overlooked, and UK manufacturers have accused Deloitte of pursuing factories in China rather than focusing on UK firms.

Deloitte is also involved with some of the laboratories handling the tests; Lighthouse Labs is a coalition of private companies, including Amazon, Boots, GlaxoSmithKline and AstraZeneca, and public bodies set up to test samples in three centres in Milton Keynes, Cheshire and Glasgow and Deloitte is involved, handling payroll, rotas and other logistics. There are significant concerns over the qualifications held by the staff and volunteers in the new Lighthouse Labs and the impact they are having on NHS-run labs.

New rules state that departments must publish the contract award notice within 30 days of agreement, but almost none have done so

Nightingale bonanza

The building, fitting out and running of the Nightingale hospitals has resulted in contracts for dozens of private companies. The big consultancy firm KPMG was hired by the government in March (under the new procurement rules with no competition) to act as a coordinator in the setting up of the Nightingale hospitals.

In Birmingham the outsourcing firm Interserve worked on the construction of the Nightingale hospital at the NEC, and it has also been awarded a contract to hire about 1,500 staff to run the Manchester Nightingale, and G4S has a contract to supply security guards for all the Nightingale hospitals.

Another large outsourcing firm, Capita, was awarded a contract to help the NHS "vet and onboard thousands of returning nurses and doctors". In the healthcare arena Capita is best known for its disastrous running of the primary care support contract, which included problems with the secure transfer of patient notes around the country, with notes going missing or delivered to the wrong surgery, and women being dropped from the cervical cancer screening programme.

Numerous other firms are profiting from the pandemic and the new procurement rules. The firm founded by Conservative donor Steve Parkin, Clipper Logistics, has been awarded government contracts to supply and deliver PPE to NHS trusts, care homes and other healthcare workers.

It is difficult not to view this large-scale influx of private companies with little scrutiny into areas that the NHS should be organising as further dismantling of the NHS and a power grab by private enterprise.

Keeping track of testing chaos

John Lister

The revelation that tens of thousands of samples from Covid-19 testing centres were being airlifted to the US for processing by a university in the southern US states is just the latest chapter in the unfolding saga of government incompetence and failure to properly utilise NHS capacity.

It must now be obvious to even the most bone-headed Boris Johnson fan that ministers and civil servants shamelessly fiddled the figures and changed their definition of a test completed to give the false impression that 100,000 tests were carried out on April 30.

Even the right wing press has now exposed the fact that tens of thousands of these 'tests' proved to be nothing more substantial than posting out over 40,000 test kits (thousands of them with no return address labels) speculatively to individuals and to hospitals.

In the run-up to Matt Hancock's self-imposed deadline to hit his self-imposed target the Department of Health even resorted to the desperate tactic of emailing the Conservative Party's ageing membership urging them to book a test.

And immediately afterwards – as Boris Johnson arbitrarily set a new impossible target of 200,000 tests a day by the end of June – reported levels of testing have slumped well below the 100,000 mark, and below 70,000 on May 6.

300-mile trips to testing centres

Meanwhile the chaos of testing continues. One Norfolk key worker was advised to get tested by 111 because there were no home testing kits available, only to be told that the nearest available 'local' drive-through testing centres were all upwards of 320 miles away, in Scotland (Perth or Aberdeen) or Northern Ireland (Belfast or Portadown). When they tried again, signing in as having been referred by 111 rather than a key worker, they were offered Nuneaton, Bakewell or Bromsgrove – the closest of them over 109 miles away.

Flying test samples to the US – on the pretext of a problem with a laboratory in Northern Ireland – indicates clearly that the new network of three unaccredited 'super-labs,' set up by the government in preference to using the established skills and equipment of the existing network of 44 NHS labs despite the opposition of the biomedical science professional body, has failed.

The Lowdown reported two weeks ago on the concerns raised by NHS laboratory staff and by the Institute of Biomedical Science over NHS laboratories having to compete for scarce reagents with the government's new "Lighthouse Labs" in Milton Keynes, Cheshire and Glasgow.

The Independent now reports further criticism from Allan Wilson, president of the Institute of Biomedical Science (IBMS), arguing that "political dogma" driving decisions on the next phase of testing for Covid-19 was causing frustration among NHS laboratories. He argues that the health service labs have more than enough capacity to do more than 100,000 coronavirus tests a day.

Instead of using these state of the art NHS machines, samples from the North East are being shipped over 200 miles south to the makeshift Milton Keynes super-lab.

NHS laboratory capacity

The BBC correspondent Sharon Barbour recently highlighted the automated machinery in place at Gateshead Hospital, capable of processing 6,000 tests a day. Similar equipment is in place in the virology lab of Newcastle's Freeman Hospital, yet instead of using these state of the art machines, samples from the North East are being shipped over 200 miles south to the makeshift Milton Keynes super-lab.

And the Lighthouse Labs have been given the lion's share of the resources. Allan Wilson points out: "Because of the lower supply we are doing 25 to 30,000 samples a day but that's only because of the supply chain. We could be doing three times as much if not more. The real constraint is the supply chain and we also end up competing with the Lighthouse laboratories."

Meanwhile to add yet another looming disaster to a seemingly endless series of cock-ups, ministers seem determined to ignore the network of 5,000 experienced local government contact tracing experts, and instead bring in private contractors Serco – and probably other equally unqualified firms such as G4S – to carry out most of the contact tracing work that logically should follow up on tests that prove positive. Serco pulled out of tendering for NHS clinical contracts six years ago after a string of contract failures in community services and primary care. Only last year they were fined £19.2m by the Serious Fraud Office as part of a settlement over an electronic tagging scandal.

Now they will be tasked with recruiting 15,000 call centre staff, who according to The Times will be given only about one day's training in the principles of contact tracing before being entrusted with a task vital to containing the virus.

What could possibly go wrong?

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!

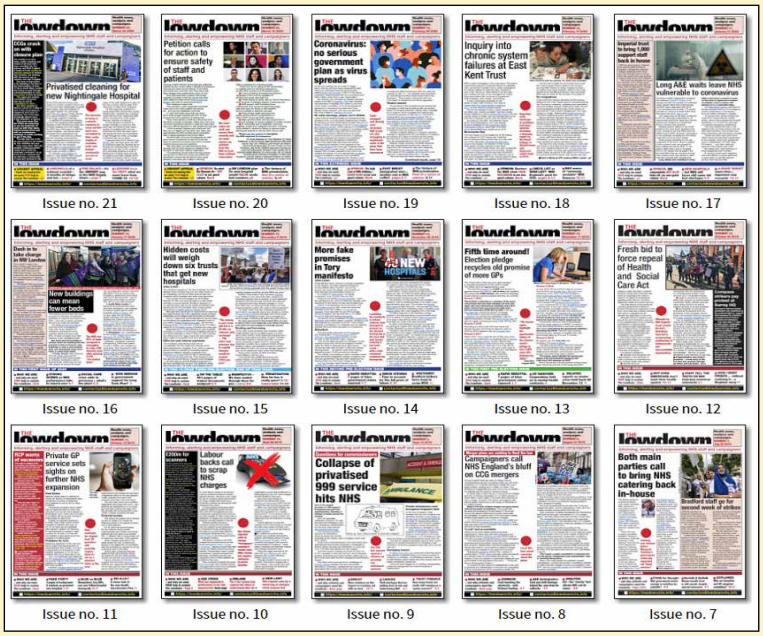
We know many readers are willing to make a contribution, but have not yet done so.

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*

Hancock complacent as care home crisis continues

John Lister

After a week of belatedly showing some apparent concern at the high levels of deaths in care homes from Covid-19, Matt Hancock and other ministers appear to have reverted to smug indifference with the announcement as ***The Lowdown*** goes to press that numbers of deaths have begun to fall back.

He told the BBC's Radio 4 Today Programme on May 12 that "I'm really pleased that the number of people dying in care homes is now falling, quite sharply. The number has almost halved over the past two to three weeks, since the peak. It's very clear to me that the transmission in care homes is coming down and is much lower than it was."

Figures from the largest charitable care home operator MHA, published on May 11, do show a substantial reduction in deaths from Covid, and ONS figures also show deaths in care homes were down in week 18, to the still much higher than average figure of 6,409. But worryingly 37.8% of those deaths involved coronavirus, up from 35.3% the previous week.

Despite government failures

And it seems clear that the reduction in the latest figures comes despite and not because of the government, which has failed to deliver the promised financial or practical support, or the necessary level of testing for the virus.

The Guardian on May 11 reported complaints from Cheshire and Birmingham that care home tests were simply not collected for processing, and an Oxford care home, whose chairman of Trustees said: "As of yesterday we still have not received any swabs to do the home testing of residents which we first requested on 27 April when Matt Hancock said that home testing was available."

Back on April 2 the government guidance to care home bosses promised:

"We will ensure a longer-term supply of all aspects of personal protective equipment (PPE) for care homes - and home care providers - so that staff can provide care, as well as providing a national supply disruption line for immediate concerns."

But even now the long-promised Amazon-style "Clipper" system, set up after the failure of NHS Supply Chain to dispatch personal protective equipment to hospitals, GPs and care homes, is not yet running or supplying vital kit for care homes, even though Public Health England data at the end of April showed the virus had established itself in more than 4,500 care homes in England, and by May 8 PHE reported that had risen by another 600 to 5,117, a third of all the 15,517 care homes. The most affected areas were the North East with 44% of care homes, and the North West with 39.5% ahead of London's 38.5%.

The April 2 government guidance also promised financial support to care homes: "We will work with commissioners to ensure fair and prompt payment for the existing care commitments and additional care provided during the response to the pandemic, recognising that both PPE and staffing costs are higher than usual."

However six weeks later concerns for the future financial viability of the care home sector, notably the thousands of smaller care home providers, have been reinforced by the continued failure of the NHS or many local councils to provide the promised support.

Even the largest providers are facing problems. On May 7 the Care Provider Alliance, representing the ten largest national care associations in England, again issued a public warning on the "significant number of providers" who are still extremely concerned about their cash flow.

"Our members have made us acutely aware of the increase in costs faced by many providers. This includes increased payroll costs due to sickness, isolation and shielding.

"Furthermore, where providers can actually access personal protective equipment (PPE) they often face costs far above normal prices.

"Although central government announced £3.2 billion had been made available to strengthen care for vulnerable people back in March, we know it's not flowing quickly from local authorities to providers."

At the beginning of May Britain's largest for-profit care home provider HC-One, weighed down by payments on bail-out loans worth more than £265m, sounded the alarm on the financial impact of the pandemic.

Seven councils – Sunderland, Birmingham, Coventry, Warwick-shire, Stafford-shire, Derby and Solihull – have invoked emergency powers to abdicate from their duty to provide for vulnerable residents

Councils that won't pay up

The CPA also warned that many councils were still simply refusing to stump up any extra funding to cover the extra costs: "We have also heard from our members' instances where health and care commissioners have advised "business as usual" and that they are not intending to provide extra funds as a result of COVID-19."

Worse still, the Independent has revealed that seven councils – Sunderland, Birmingham, and Coventry city councils, Warwickshire, Staffordshire and Derby county councils and Solihull council – have so far invoked emergency powers in the Coronavirus legislation to abdicate from their duty to provide for vulnerable residents.

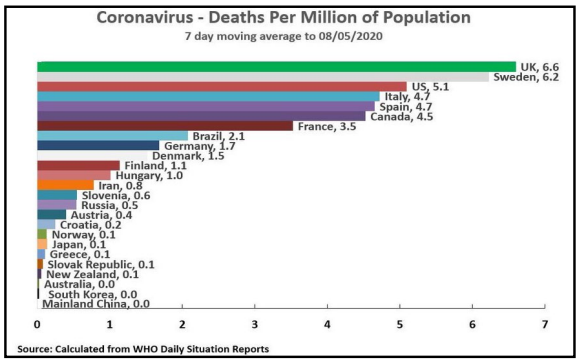
The case for sweeping reforms to bring the failing network of privately-run care homes into a publicly owned, funded and delivered National Care Service has been significantly strengthened by the revelations, while the visible reluctance of cash-strapped councils to shoulder any responsibility for the most vulnerable people suggests they are unfit to run such a system in the future.

How many people have really died from Covid-19 infection?

Sylvia Davidson

The true death rate due to infection with Covid-19 has been a source of controversy ever since the government began its daily briefings and announcements of the daily death figures.

Initially, the government figures included only deaths in hospitals, then after some considerable amount of pressure, from 29 April the figures included deaths outside of hospitals, including in care homes, hospices and at home.



But the figure still only includes those that have tested positive for the virus. As a result, many believe that the government's figures are a significant underestimate of the death toll, which they believe to be well over 50,000 already.

On 12 May 2020, the Office for National Statistics (ONS) announced that 35,044 deaths were registered in England and Wales by 9 May with Covid-19 mentioned on the death certificates. With the addition of deaths in Scotland and Northern Ireland and the more recent deaths announced daily by the government, this takes the UK's death toll to 40,011, the highest death toll in Europe from coronavirus.

Last week the UK became the worst-affected country in Europe, and these figures mean that this position continues. According to data collated by Johns Hopkins University, Italy has recorded 30,739 deaths, Spain 26,744, and France 26,604, Germany has recorded just 7,661 deaths.

Chris Giles of the ***Financial Times*** believes that the figures from the ONS of deaths due to Covid-19 are a considerable underestimate. Soon after the ONS publication on 12 May, the FT reported that excess deaths were above 50,000 and this is a better indication of the level of deaths due to the virus.

Excess deaths are those that are in excess of the five year average seasonal mortality reported by the ONS.

Chris Giles, Economics Editor for the FT, notes that the methodology uses the weekly figures released by the ONS of death registrations and the daily figures released by the government, and takes into account people who have died but not been tested for Covid-19, people who were unwilling or unable to get to hospital for some reason, plus effects of the lockdown (for example, increased domestic violence, but lower traffic accidents).

For the week ending 1 May, there were 8,012 excess deaths in England and Wales; this was the seventh consecutive week that deaths exceeded normal levels. After adding the equivalent figures from Scotland and Northern Ireland total mortality across the UK during the pandemic was 50,979, according to the FT model.

The last two weeks of figures from the ONS have shown just how great a toll the pandemic has taken in care homes around the UK. The normal level of death registrations for care homes in England and Wales at the end of April is just over 2,000, the figure reported by the ONS for the equivalent week, ending 1 May, was 6,409; this is more than three times the normal rate.

Past the peak?

According to the ONS data deaths in care homes have begun to fall for the first time and the peak is likely to have been be passed, but as Henry Lau of the ONS pointed out they are still higher than the deaths in hospital.

The ONS data (shown below) indicates that the proportion of deaths in hospital due to Covid-19 is decreasing. In recent days the proportion of deaths in care homes due to Covid-19 has risen to 40.4% of all deaths registered due to the virus.

It is now clear that the focus on hospitals and freeing up hospital beds has been a major error that has cost many lives.

Carl Heneghan, professor of evidence-based medicine at Oxford university, criticised the decision to move infectious people into care homes when he spoke to the FT:

"Clinically, it just doesn't make any sense whatsoever to put a person with an active infection into a home setting where other people are in significant numbers and are vulnerable."

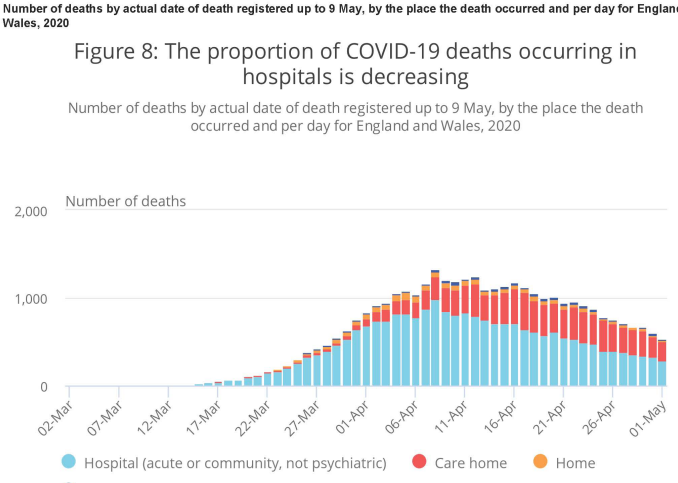
Finally, last week in the 5 May press conference, the government seemed to acknowledge that there is an issue.

Professor Angela McLean, the UK's deputy chief scientific adviser, admitted that they need "to get to grips" with what is happening in care homes after noting that "whilst deaths in hospital have been falling, deaths in care homes in the week to 24 April were still rising."

Good that it has now been acknowledged: however this is way too late for those who have lost their lives due to the government's policy early on in the pandemic.

Figure 8: The proportion of COVID-19 deaths occurring in hospitals is decreasing

Number of deaths by actual date of death registered up to 9 May, by the place the death occurred and per day for England and Wales, 2020



Source: ONS. An interactive graph is available *online*

Is it back to normal for non-Covid patients?

Martin Shelley

We've crested the first wave, so we're done, right? Not exactly, in fact not at all, save for some minor lockdown tweaks. The headline-grabbing £14bn of emergency "whatever it takes" public sector funding is still desperately needed, and it'll be a while before the post-pandemic planners consider it safe to return the hastily converted (and swiftly closed) Nightingale sites to their rightful owners.

The patients whose urgent diagnosis and treatment came to a juddering halt last month, the pent-up demand (judging by the 50 per cent drop in A&E visits recorded in April) from people who have been too scared to access services, and the backlog of bread-and-butter non-urgent elective surgery (more than two million operations, with a waiting list as high as 7.2 million predicted by private "virtual healthcare provider" Medefer) suggest a second or even third wave of patients could pound the NHS' battered defences after the Covid-19 pressure eases.

Research by NHS data provider Edge Health has even suggested indirect deaths could eclipse the carnage eventually wrought by the virus.

To assess how well it's going to cope, let's consider the NHS' existing strategy and its impact on five healthcare groups, before going on to look at its plans to restore service provision to pre-pandemic levels.

Cancer

Screening services for cancer have been paused across the UK during the pandemic, despite NHS England claiming last month that its national programme is continuing. Breast, bowel and cervical screening can detect the disease before any symptoms show, in the early stages when treatment is more effective.

But around 200,000 people per week are no longer receiving that screening, according to Cancer Research, so there will be a significant number of early cancers left undetected – as many as 2,000 a week, many of which may become inoperable – before these services can be reintroduced. National charity Bowel Cancer UK suggests that people aged 60-74 with undiagnosed bowel cancer may suffer worse outcomes as a result of later diagnosis.

Fewer people are also going to see their GP with cancer symptoms, which has resulted in an average drop of 25 per cent in urgent referrals in England – one hospital even reported a 90 per cent fall – while in Scotland weekly numbers are down from an average of 2,700 to just 744.

This is partly because some GPs are reluctant to risk sending patients to hospital for fear of Covid-19 infection. So, for every week that this goes on, more than 2,300 cancer cases are likely to be going undiagnosed across the UK. Referrals overall have fallen by 62 per cent

And fears over Covid-19 infection have led to reductions in diagnostic testing too, especially for lung cancer, the most common cause of cancer-related deaths. Clinical trials have also been paused or discontinued and others have simply stopped recruiting, again because of the pandemic, says Cancer Research. Chemotherapy appointments – said to be down by 30 per cent – and palliative care have also been hit because the infection risks have been too high, and some patients have been denied major surgery because of a lack of ICU and recovery beds.

A joint study by University College London and Health Data Research UK, released at the end of April, forecast that there will be 18,000 more cancer deaths over the next 12 months, an increase of 20 per cent, because of the impact of the pandemic.

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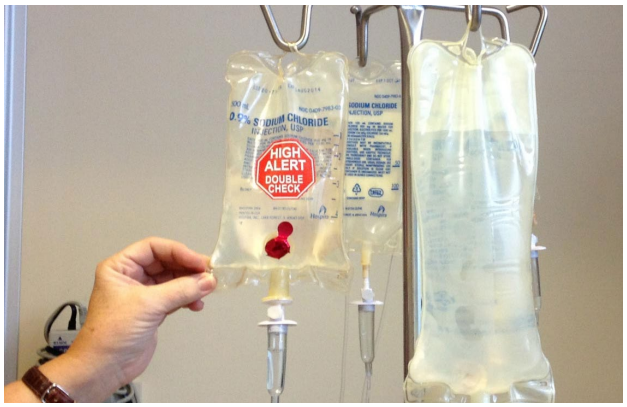


Strokes

Pressure on NHS beds may be subsiding now we've 'passed the peak', but as recently as 16 April NHS England updated its guidance to suggest freeing up beds in specialist units currently occupied by stroke patients, to make way for those suffering from Covid-19, was "paramount".

District general hospitals, which no longer regularly treat the most seriously ill stroke patients and may not have ready access to blood-clot-dissolving thrombolysis equipment, were suggested as an alternative home for the displaced patients.

At the time of writing ***The Lowdown*** is unaware of any further guidance having been issued.

Mental health

GPs have warned of difficulties diagnosing and managing patients' mental health during the pandemic – including those developing specifically virus-related issues – because of the necessity for 'digital' (ie remote) appointments. A spokesperson for the Royal College of General Practitioners claimed that remote consultations were likely to make some patients feel less comfortable approaching their GP, and that many of them will want to revert to face-to-face contact as soon as possible.

Meanwhile, the Royal College of Psychiatrists (RCP) says that some medical directors are reporting an "upsurge in really acute mental illness" following nearly two months of remote consultations, with one suggesting more psychiatric intensive care beds were now needed.

The NHS' existing mental health 'estate' was already under stress before the pandemic broke, with a lack of beds and inappropriate dormitory wards – the latter a major barrier to Covid-19 infection control – so local trusts may now be forced to limit admissions at some stage.

The RCP chair Dr Agnes Ayton warned earlier this month that some specialist eating disorder units across the UK have had to run below full capacity precisely because of those limitations, at the same time as specialist charity Beat is claiming calls to its helpline have risen by 35 per cent since the pandemic began.

Child health

Lower take-up levels during the pandemic no doubt prompted the Royal College of General Practitioners last month to urge parents to continue participating in routine vaccination programmes for their children. Meanwhile, the Royal College of Paediatrics & Child Health (RCPCH) reported a dramatic fall – 50 per cent – in the number of safeguarding referrals and referrals to children's sexual assault services, and has expressed concern over increased waiting lists at community paediatric departments across the UK. It also claimed that waiting lists for assessment of ADHD and autism were already up to 24 months in some areas.

Since the lockdown referral rates to child and adolescent mental health services – normally subject to waiting lists of several months for a first appointment – are said to have plummeted, with the support services that redirected referrals on to them now shut, and young service users at risk of overdose reluctant to present at A&E departments.

Dental care

It's unclear yet exactly how the government is planning to ease the restricted access to dental services.

At the end of March dental practices were told to suspend all routine treatment, but the replacement service – 165 urgent dental care 'hubs', supported by remote phone appointments and backed up with hospital-based emergency treatment – has not been a complete success, with GPs last month experiencing a rise in calls from patients who, when referred on to the hubs, often had difficulty getting appointments.

Then, at the beginning of May came reports that the four hubs in Hertfordshire, catering for more than a million residents, had shut after the NHS refused additional funding to pay for their operation.

Dental charity Alpha Omega claimed recently that, if the government opts for a phased approach to easing the suspension of routine treatment, "there will be no dental practice that can survive financially on that kind of work".

So what does the future hold?

Following up on an announcement by health and social care secretary Matt Hancock two days earlier about plans to restore non-Covid-19 services, on 29 April the NHS' chief executive Sir Simon Stevens and CEO Amanda Pritchard outlined the 'second phase' of the health service's response to Covid-19, clearly aiming to address many of the issues highlighted above.

They urged primary care providers to restore cancer services and cardiovascular care, and to 'step up' non-Covid-19 urgent services to pre-pandemic capacity levels as soon as possible over the following six weeks, and pressed them to assess whether some non-urgent elective surgery can resume.

Quite how easy all this will be to achieve is unclear, and un-costed, although an estimated 37,500 NHS beds (40%) are empty in England. It has been estimated that just clearing the backlog of non-urgent surgery could alone end up costing the NHS £3bn, raising the politically sensitive prospect of healthcare being rationed until the waiting lists are slashed.

The Royal College of Surgeons has warned clearing the list could take five years.

On the same day as the statement from Stevens and Pritchard, the Royal College of Emergency Medicine (RCEM) warned that major changes to the way A&E departments operated were urgently needed to reflect the need for increased infection control and strictly enforced social distancing – possibly through the creation of separate Covid and non-Covid A&E zones for the duration of the pandemic. RCEM president Katherine Henderson told healthcare journal HSJ:

"The idea that we can have a patient in a corridor now we have an endemic, contagious, un-vaccinate-able, untreatable infection that affects the older population, who are precisely the people who ended up in the corridors, is so impossible that we need to get a move on to make sure it doesn't happen."

University Hospitals Birmingham NHS Foundation Trust has already made a move in this direction, ring-fencing its Solihull site for non-Covid elective inpatient care, reflecting a growing enthusiasm among some NHS trust leaders to restart routine elective surgery gradually, area by area and depending on local infection rates, as mooted by Hancock on 27 April.

Back to 'business as usual' then?

Hardly. Nobody knows how the NHS' post-first wave strategy will play out over the coming months, but without safe and effective treatments and vaccines – and more consistent political messaging – it looks like we'll be dependent on the truly heroic efforts of frontline NHS staff for a long time yet.

The Royal College of Emergency Medicine has warned that major changes are urgently needed to the way A&E departments operated to reflect the need for increased infection control

Rebuild our health and social care: the lessons from the Covid crisis

PAUL EVANS

The NHS can't be allowed to return to perpetual crisis, we must convert public gratitude into political pressure to solve the long standing problems in health and social care.

Why do we need to rethink?

Before the virus, the NHS was in its familiar state of high pressure, heading for winter after publishing its worst ever performance figures; missing targets for A&E care, operations and cancer treatment.

Perpetually it works too close to the edge and often over it. At Christmas doctors in a Norfolk hospital were told to make the "least unsafe decisions" in managing patients. Little did they know what was to come, but staff across the NHS were already accustomed to seeing care compromised by the pressure.

Recent studies show that over 3 a three year period 5,500 patients died because they spent too long waiting on trolleys, another identified 1100 deaths from bowel disease because of staff shortages.

Despite both the publication of the NHS 10 year plan in January 2019 and an election campaign brimming with dubious pledges there is still no credible strategy for increasing the capacity of the NHS and social care to levels that meet the needs of our society.

It took Covdi-19 to get ministers to focus on capacity, and yet the speedy opening of the Nightingale hospitals - which have gone largely unused: but the restriction of many other non-covid NHS services, proves that we must have a system capable of proper long term planning.

The use of the private sector as the preferred suppliers for testing, pathology and contact tracing during the Covid crisis, even when NHS and public sector facilities are available, is a further worrying indication that policy makers are not fully on board with building-up NHS capacity.

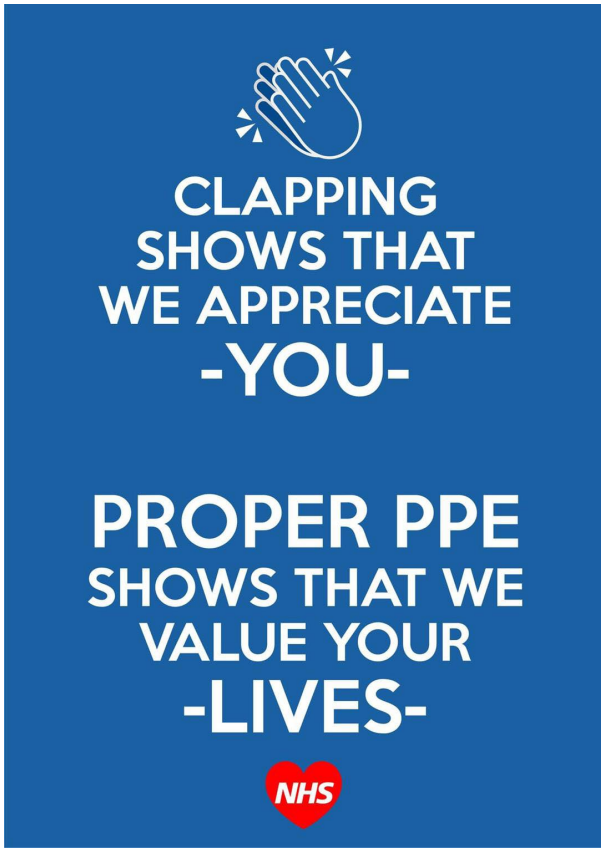
Surge in demand

A post-Covid surge in patient demand is widely predicted. Thousands of people are waiting at home for treatments that were postponed by the virus.

Cancer Research tells us that over 2000 cancers a week are currently going undetected, many mental health patients are struggling on their own. GP appointments have dropped by 30%, but with a huge wave of patients expected.

The capacity issue is pressing, but it's not new. The gap between the demand for healthcare and the amount of staff, beds and equipment needed to supply it, has been growing for a decade.

The NHS has cut its bed stock by 11% (144,555 down 128,326), over the last 10 years - although



The use of the private sector as the preferred suppliers during the Covid crisis, even when NHS and public sector facilities are available, is a further worrying indication policy makers are not fully on board with building-up NHS capacity.

they have risen slightly in the last year.

Over the sametime hospital activity has risen by around 22%. The number of people on waiting lists has risen by 44% in just the last five years.

Planners don't appear to have got the message. The six new hospitals that have been given the go-ahead under Boris Johnson's premiership are already faced with the prospect of bed shortages and inadequate capacity – before a brick has been laid.

Until the virus hit, bed occupancy across the country was running at 90% on average and often higher in the busiest hospitals. The maximum safe limit is widely judged to be 85%. So why don't we plan around achieving it?

Revise strategy

Matt Hancock has promised to revise the current strategy so that it "takes account of the NHS's capacity to achieve our wider goals in light of developments with Covid-19, once the virus has been effectively managed."

This should mean an overhaul of the NHS Long Term Plan to decide what can realistically be achieved at the current capacity and to set a genuine path for NHS expansion.

So far core elements of the 10 year plan are being

pushed forward before the workforce strategy or the money to support it have been finalised - akin to pushing a car off the production line without an engine.

An example is NHS England's big idea to transfer healthcare out of hospitals - where it is relatively expensive, and to treat more patients in the community, managed through the formation of new Primary Care Networks.

Nothing wrong with closer teamworking between GPs, pharmacists and community staff, or in siting care closer to home if properly organised, but the plan has so far meant loading already overworked GPs and community staff with extra responsibilities. Without the extra capacity this pivotal scheme is seen by half of GPs as "unmanageable"

One family doctor told GP online: 'Sadly it appears to me that there is an expectation that GPs are going to sort out the problems for the NHS through primary care networks; how will this work? Primary care needs a political solution to solve the problems around recruitment and demand.'

The Long Term Plan has aspirations that few would disagree with; about the need to improve detection rates, make services more equitable and to speed up treatment, but these goals can't be achieved without genuine plans to raise capacity and there are serious flaws in the framework that the plan is built upon.

Failed reorganisation

The last NHS reorganisation - laid out in the Health and Social Care Act 2012, was gargantuan, but failed. Its structure is still legally in place, leaving fragmented players still half acting out the old competition script of buyers and sellers.

Quietly though, the NHS has undergone another shakeup. CCGs have merged into much larger Integrated Care Partnerships. Despite promises, no new legislation is yet in place and so the end point, governance and accountability of these bodies is unclear.

Meanwhile important local decisions, changing local services are being made more remotely from the public. The new goal is integration, but huge questions remain: is there joint funding and organisation for health and social care? Who will take the lead planning role? How will they be accountable? What's the role of commercial companies and how will that be regulated? So far we are left guessing.

Duty to provide

Until the Health and Social Care Act the public had one comforting certainty that the Health Secretary had a duty to provide healthcare. With that removed - by Cameron's government, It is now hard to see who is ultimately responsible for ensuring that we all receive the care that we need, which leaves us all more vulnerable.

Replacing it is a rash of public reassurances and fantastic claims: "40 new hospitals", "50,000 new nurses", "record funding for the NHS", but there is still no effective strategy to make sure the arms of the NHS can still reach all those that need it.

Who would have thought that the bustle and crowds we once had in NHS hospitals would turn out to be the good old days?

Analysing the government's funding commitment chief economist for the Health Foundation Anita charlesworth said:

"Even with the government's proposed investment, the health service will struggle to maintain current levels of patient care in the face of growing demand, let alone deliver the ambitious improvements to services promised by the NHS Long Term Plan."

Staring straight down the camera ministers promise us that "the NHS will get all that it needs", but so far they haven't delivered - health economists agree that the 3.1% rise a year across this Parliament is significantly under what is needed.

In fact the proportion of our GDP that we spend on health is falling - which starkly reminds us that the government is doing far less than could be afforded.

The government has created a £14bn Covid fund for all public services, but that is emergency cash not the long term investment plan that is needed.

Backlog

Ten years of rising demand, starved of adequate resources has led to crisis management and a £6bn backlog in hospital and GP repairs and building work.

There are signs too within the NHS Plan of a continued sell off of NHS estate which begs the question how will the new infrastructure and community facilities that we need be built? More leasing from the private sector?

Disgracefully too, we are no nearer a solution for social care, The Conservatives have promised £1bn per year over the course of the parliament to shore up social care, but again economists put this in perspective.

"...this won't come close to the £4.1bn needed by 2023/24 to address the costs of rising demand and match NHS pay increases. In the meantime, more people will go without the care they need."

Almost 5000 former NHS employees came out of retirement to stand on the frontline to fight Covid-19, but even their valiant support isn't enough. The NHS is short of 100,000 staff and in social care the gap is 122,000.

The challenge to raise capacity so that services are safe and effective is huge and on the other side of this terrible virus we need a plan, a much better plan to achieve it.

It is now hard to see who is ultimately responsible for ensuring that we all receive the care that we need, which leaves us all more vulnerable

Stay alert, control the eugenicists, save lives

This is a shortened article from the *People's Cries* blog. Full text online.

I am responding to a document that was issued by the Clinical Commissioning Group in Hackney last week. Hackney has seen the third highest number of Covid-19 deaths of any borough. The bulletin was sent to all primary care staff and institutions in City and Hackney on 1st May, 2020; I have changed one sentence to italics, and added the meanings of abbreviations used in brackets.

At a time when there is a continuing high death toll from Covid-19 of people in care homes, when hospital wards are relatively empty and indeed the ExCel centre facility has been mothballed for lack of use, I am concerned about the grave errors in this document.

It instructs GPs and their teams to accelerate the process of getting people in the community who have moderately impaired mobility (for example, difficulty climbing stairs) – that is, Frailty score grade 6 or above – to agree to Advanced Care Plans – a reasonable, if rather bureaucratic ambition, and not one that one would hope busy GPs should be spending time on during a pandemic.

Such care plans, the document explicitly instructs, are to be used to encourage frail people, if they are suffering from Covid-19, to agree to being looked after at home.

The case for this is argued on the basis of evidence, which I do not dispute, that such frail people will not benefit from mechanical ventilation.

Regular checks

However, being admitted to hospital where you can have your oxygen saturation regularly checked, can be given oxygen if necessary, can be nursed by trained professionals, can have physiotherapy, can have antibiotics and other drugs, and can access numerous other benefits, is not at all the same stage in the process of care as when your condition has further deteriorated, when you and the team looking after you are faced with the question of your being mechanically ventilated or not.

Moreover, in hospital you will be looked after by staff who have relatively greater access to PPE and are trained to use it, whereas in the community you may continue to spread the disease, with any carers you have access to being ill-equipped to avoid becoming vectors of the infection, passing it to yet more frail people.

Finally, of course, assessment in the hospital setting does not necessarily mean admission to hospital, it just means that the decision as to whether hospital care would be beneficial is guided by much stronger evidence, such as a chest x-ray, arterial oxygen levels, CT scan of chest, a Covid-19 antigen test, or whatever else is deemed necessary to improve that decision.

To use a person's Advanced Care Plan as a guide to action as to how to treat them … is a travesty which anyone would be hard pressed to deny has eugenicist connotations

The effect of the CCG's instruction is to deny patients that quality of assessment, which cannot be provided in the community. Such assessment is MORE important if you are frail, not less, because the presence of other chronic conditions – chronic lung disease, or cardiovascular disease, for example – makes the clinical assessment more difficult.

I myself, if asked to make an Advanced Care Plan, would definitely opt for dying at home rather than dying in hospital. This has absolutely zero relevance as to decisions, if I am stricken with Covid-19, about which clinical setting will provide me with optimal care, or even which setting I would prefer.

Hope of recovery

As far as we know, anyone with even quite severe Covid-19 infections can still hope to recover fully, however bad their underlying health – it is only when they are critically ill with the infection that those with serious underlying conditions, including moderate frailty, have to resign themselves to the likelihood of death.

To use a person's Advanced Care Plan as a guide to action as to how to treat them in the middle of a pandemic, in the community, where the severity of that person's infection is hard to judge, being made without any tests or investigations, is a travesty which anyone would be hard pressed to deny has eugenicist connotations.

The paper's assertion that there is a "lack of benefit with hospital admission amongst patients with CFS6 or greater" is a barefaced inaccuracy amounting to a falsehood.

This confused and possibly wilfully wrong message will have tended to make its readers hesitate to send people to hospital even when they would actually benefit from hospital care.

It seems to be aimed at inducing what might be referred to as herd behaviour on the part of doctors in the community, giving them a get-out clause from the paramount ethical obligation to consider the needs of the person whom they are treating, consideration which of course always necessarily, when it comes to taking action to meet those needs, has to take account of what resources are available.

It seems possible that this advice may already have cost the lives of many of the most vulnerable of Hackney's citizens, particularly those whose frailty is compounded by other disadvantages – being black or brown, being poor, being socially isolated and without articulate mentors and so on.

I would very much like to know whether it is based on instructions from NHS England, or whether it is a purely local mistake.