HEALTH CAMPAIGNS TOGETHER #our NHS

MONTHLY ONLINE NEWS BULLETIN #4 JANUARY 2021

£600m "extra" is too little, too late for crumbling hospitals

Massive 38% increase in NHS backlog maintenance bill

On December 10 a new £600m investment into NHS hospitals across England, apparently aimed at "upgrading and refurbishing" hospital sites, was announced by Health Secretary Matt Hancock.

It will be welcomed by the recipient trusts, but it's not new money. It forms part of the £1.5bn capital funding announced by Boris Johnson over the summer to help the NHS 'build back better'.

While it's better to receive

something than nothing at all, most people would expect trusts to be able to afford such minor sums to cover most of the projects on the long list from routine funding.

But this vital work of maintaining NHS hospitals is falling behind. The "extra" £600m was less than one tenth of the (2018-19) estimate of the total backlog maintenance bill of £6.5 billion. But the latest figures for 2019-20 show that the backlog has rocketed by

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Avoidable crisis

The death toll soaring above the 80,000 mark, ambulances queuing for hours outside hospitals full to capacity, staff worked to and beyond reasonable limits with 46,000 off sick with Covid 19: the picture could not get much worse.

But it did not have to get this bad. The NHS is not only suffering the impact of the Covid pandemic alongside what has become a "normal" winter crisis, it went into to crisis weakened by a decade of effectively frozen real-terms funding, and with staffing levels depleted by 100,000 vacancies after year on year of real-terms cuts in pay and worsening conditions.

NHS frontline staff have not been prioritised for vaccination, despite the tragic death toll from the first wave of Covid. In the care sector too, where so far only 10% of care home residents and 14% of staff have been vaccinated, the National Care Forum says some care services have more between 11% and 50% of staff off sick.

Brexit has also driven out large numbers of NHS professionals and social care staff, while Priti Patel's vicious new immigration

restrictions will prevent any social care staff being recruited from Europe or elsewhere: yet bizarrely from such a zenophobic government there are still no proper controls over people flying in to the country.

When the pandemic hit we already had the lowest provision of hospital beds of any comparable country: but another 5,000 general and acute beds have closed in the last 12 months, and many more remain unused because of social distancing.

But the NHS alone could not deal with Covid: to contain the virus needs testing, tracking and tracing those infected, measures to ensure infected people without symptoms are quarantined. Ministers have failed at each stage to take prompt or effective action.

Time and again warnings have been ignored, lockdowns delayed and prematurely lifted, huge contracts for testing, track and trace have been handed to incompetent private companies rather than established public health experts,

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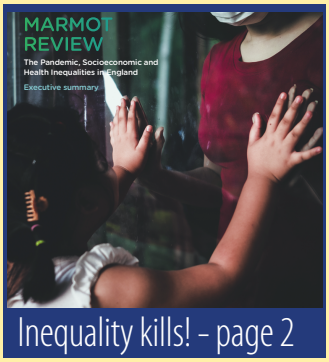


ALL inpatient mental health beds for children and young people closed in Bristol area

Protect our NHS (Bristol)

Six months ago, Protect our NHS (Bristol) was shocked to learn that there were no longer ANY local residential mental health beds for children and young people in need of this provision.

This situation was due to the closure in April 2020 of Bristol's NHS unit – the Riverside Adolescent Unit - for a year-long refurbishment.

This treatment unit was replaced by beds located in two wards (Banksy and Brunel wards) in The Priory, a private hospital in Bristol, but both wards were closed over the summer due to severe staffing problems.

The alarming situation at The Priory that led to a rating of inadequate by the Care Quality Commission (CQC) and sudden ward closures was reported in detail by the Bristol Cable newspaper.

Since this closure, an expanded community service has been set up to provide home care for all children who are acutely unwell with serious mental health problems – a situation which our local CCG appear to consider acceptable.

Protect Our NHS is publicising and challenging this loss of inpatient care which we consider to be a vital aspect of any mental health service. It signals an appalling state of affairs for our city's children.

No child should be sent far from home at a moment of crisis: all need their family and friends to be near them.

Private sector failure

What has happened in Bristol is a shocking example of the dangers we face when relying on the private sector to provide vital services, especially those required by such a vulnerable population.

In the last 18 months, the hospital care for children provided by The Priory in England has been closed down on three separate occasions after being rated inadequate by the CQC.

In the process of campaigning locally on this issue, we have come to understand that a major impact of the savage cuts to children's mental health services has been the catastrophic loss of mental health staff, especially nurses.

The Tory government has slashed funding, including training bursaries, so that we now have 6,000 fewer mental health nurses than in 2010.

What is happening in your region: is this a national problem?

We believe that Bristol's loss of residential mental health beds for children and young people is an example of a national phenomenon. As such, it requires a national campaign.

● If you would be interested in working with us and others to mount a bigger campaign, contact ***ronmendel1947@gmail.com***

Marmot: inequalities worsen Covid impact on BAME population

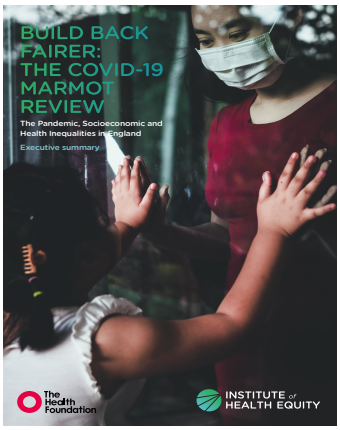
Build Back Fairer; the Covid 19 Marmot Review is an even harder-hitting update of the February 2020 publication on inequality and health ***The Marmot Review 10 Years On***.

Prof Marmot begins with the stark, simple warning that "The levels of social, environmental and economic inequality in society are damaging health and wellbeing."

The report goes on to add the lessons from the handling of the Covid pandemic to the damning conclusions on the ten years from the first landmark Marmot Review in 2010.

A year ago the report stated:

"Since 2010 improvements in life expectancy in England have stalled; this has not happened since at least 1900. If health has stopped improving it is a sign that society has stopped improving. When a society is flourishing health tends to flourish.



… "Life expectancy follows the social gradient – the more deprived the area, the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased."

… "For both men and women, the largest decreases in life expectancy were seen in the most deprived 10 percent of neighbourhoods in North East England and the largest increases in the least deprived 10 percent of neighbourhoods in London."

… "The gradient in healthy life expectancy is steeper than that of life expectancy. It means that people in more deprived areas spend more of their shorter lives in ill health than those in less deprived areas."

Now among other findings the Marmot inquiry has emphasised the way the inequalities impact most heavily on the BAME population:

"The links between ill health, including COVID-19, and deprivation are all too familiar. Less so have been the findings of shockingly high COVID-19 mortality rates among British people who self-identify as Black, Bangladeshi, Pakistani and Indian.

"Much, but not all, of this excess can be attributed to living in deprived areas, crowded housing and being more exposed to the virus at work and at home – these conditions are themselves the result of longstanding inequalities and structural racism.

"There is also evidence that many people from Black, Asian and Minority Ethnic (BAME) groups have not been well protected at work, and less well protected than their White colleagues."

■ **The report will be more fully analysed in the next issue of The Lowdown.**

NHS bed numbers axed as pandemic takes hold

As this bulletin is completed the HSJ has just reported the number of hospital patients being treated for Covid19 has risen above 30,000 for the first time, 62% higher than the previous peak last spring, at **32,070**.

According to the HSJ this is "just under a third of the total beds available": sadly this is not quite true, indicating the sheer number of front line beds that have closed.

NHS sitrep reports show that a year ago, on December 30 2019 there was a total of 97,683 general and acute beds available, combining "core" and "escalation" beds. 94% of these (91,985) were occupied.

By contrast on December 30 2020 the total of general and acute beds available had fallen to 90,970 – a reduction of 6,713 (almost 7%): and of these only 80,066 were occupied (88%).

NHS England notes the impact of Covid on the use of beds:

"Hospital capacity has had to be organised in new ways as a result of the pandemic to treat COVID-19 and non-COVID-19 patients separately and safely in meeting the enhanced Infection Prevention Control measures.

"This results in beds and staff being deployed differently from in previous years in both emergency and elective settings within the hospital. As a result, caution should be exercised in comparing overall occupancy rates between this year and previous years.

"In general hospitals will experience capacity pressures at lower overall occupancy rates than would previously have been the case."

However such a large reduction in numbers of available beds coupled with a reduction in occupancy level means that services now have even less resilience and capacity to cope.

As a resource to campaigners Health Campaigns Together has begun to publish updated graphs illustrating the number and proportion of available beds filled with Covid patients, plus other data as they become available.

On December 11 Protect our NHS (Bristol) were outside the Weston super Mare office of "anti-corruption champion" John Penrose MP, asking how come his unqualified wife Dido Harding got her job as head of the outsourced Test and Trace. It's one of many jobs gifted to members, cronies and donors to the Tory family ...

Avoidable crisis ... from front page

NHS laboratories have been sidelined by new part-privatised labs.

To make matters worse, despite spending billions, ministers have failed to provide support to ensure that all of those who should isolate can afford to do so. Estimates suggest fewer than 20% of those who should isolate do so fully. Only 12% get a test, 18% isolate, and 11% of contacts isolate properly.

The root of this is inequality and austerity-driven cutbacks in welfare payments.

The UK has one of the lowest proportions of income covered by statutory sick pay in Europe – and millions of the lowest paid don't even qualify for the miserable £95 per week.

By contrast authorities in New York improved compliance by paying people generously to stay home, offering practical support including pet care, collecting medicine or groceries, and using hotel rooms to help people isolate from shared or crowded accommodation.

Short-sighted Treasury-led decisions have left millions excluded from support.

Initiatives such as "eat out to help out"; repeatedly ignoring expert advice, and the lack of any proper strategy have all stunted and distorted the effort to combat Covid, leaving the NHS more exposed, with warnings services could be completely overwhelmed.

We didn't have to be in such a disastrous situation: but without a serious change of policy we are likely to remain in it for a prolonged period even as the vaccine is rolled out.

Support

It's time for ministers to turn away from their cronies and start listening to the experts and health professionals, and tighten down the lockdown, together with a new package of support to the millions who cannot afford to isolate.

And, of course to revisit the inadequate plans for revenue and capital funding the NHS, and invest sufficient extra now and in the next few years to ensure buildings can be maintained, adapted as necessary and expanded, and staff can be fairly paid after years of tight-fisted austerity.

Backlog maintenance (from front page)

42 % in a single year -- to £9 billion – almost the whole of the latest capital allocation.

The official figures highlighting this new, higher backlog state: "This is also known as 'backlog maintenance' and is measure of how much would need to be invested to restore a building to a certain state based on a state of assessed risk criteria. **It does not include planned maintenance work** (rather, it is work that should already have taken place)."

But capital spending is set to fall again in real terms next year.

The latest announcement does not represent any big vision. The money is to be spent quickly – by the end of March. The list of almost 1,800 projects across 178 trusts projects (averaging £3.4m) is a series of mainly small, overdue projects (as low as £4,000) to attend to long standing under-funding of maintenance and new equipment.

Back in August 2019 NHS Providers argued:

"The NHS' annual capital budget is now less than its £6bn backlog maintenance bill (which is growing by 10% a year)…. Per head of population, we have fewer CT scanners than Slovenia, the Russian Federation, Turkey, and the Czech and Slovak Republics, and less than half the number you will find in Latvia, Greece and Iceland."

■ This article updated from ***The Lowdown*** December 23

Consultation closed – full speed to ICSs?

NHS England/Improvement (NHSEI) have now concluded their perfunctory consultation on the details of new legislation which they want the government to enact early this year. They hope to give legal legitimacy to changes establishing Integrated Care Systems (ICSs) which are already well advanced.

This has required a process of merging (and eventually abolishing) CCGs, which were established as public bodies by the Health & Social Care Act 2012.

The consultation was unreported by mainstream media and largely eclipsed by the Covid crisis, so the implications of the proposals are not widely understood by the public or NHS staff.

However the final few weeks of the consultation have seen increasing expressions of doubt, perhaps most conspicuously and surprisingly from the Local Government Association (LGA), a normally conservative all-party body which represents the leaders of 335 of England's 339 local authorities. Their response states:

"We are concerned that the changes may result in a delegation of functions within a tight framework determined at the national level, where ICSs effectively bypass or replace existing accountable, place-based partnerships for health and wellbeing….

"Calling this body an integrated care system is to us a misnomer because it is primarily an NHS body, integrating the local NHS, not the whole health, wellbeing and social care system."

The Health Service Journal has pointed out how vague the proposals are: "… ICSs will be given a "single pot" of money from which to manage spending priorities. But there is no framework for how this will be spent that assures fairness, value for money and quality outcomes."

Many GPs fear primary care, would once more be marginalised in ICSs dominated by large-scale acute hospital trusts, while NHS Providers, representing trusts and foundation trusts, has also expressed reservations, warning that: "trust leaders … are cautious about any top-down, inflexible reorganisation of the NHS, particularly in the middle of a pandemic."

■ This article is much shortened from an original in The Lowdown.

NHS England demands "top quartile" productivity from pandemic-hit trusts

John Lister

The NHS England's inglorious tradition of sending out massively complex and burdensome letters to NHS leaders the day before Christmas Eve has continued – even in the midst of a fresh peak of Covid infection.

The latest December 23 letter, from Amanda Pritchard, CEO of NHS Improvement and NHS Chief Operating Officer and Julian Kelly, NHS Chief Financial Officer, will have dragged down morale for senior management and left them dreading the ever-expanding list of tasks to be tackled in the new year.

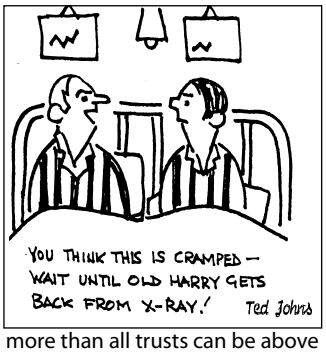
Roy Lilley of nhsmanagers.net mocked the letter's redundant instructions such as "… maintaining rigorous infection prevention and control procedures continues to be essential;" and "minimise the effects of emergency department crowding."

He dismisses the authors as "the dumb duo": "This junk-mail is from someone, a former chief executive of a Trust, who appears to have forgotten where she came from, … the other signatory to the letter, I've never heard of... if you meet him, show him a picture of a hospital, it's probably the closest he'll get."

But surely the most implausible and impractical proposal is the one highlighted by the HSJ report:

"… we will set an aspiration that all systems aim for **top quartile performance in productivity** on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/ orthopaedics."

Top quartile productivity is by definition not attainable by all, any more than all trusts can be above average.



And while ophthalmology and orthopaedics might possibly be able to maintain Covid-free services, it's unlikely many cardiac services will be able to do so in competition with the expanded bed provision for Covid patients.

Pritchard and Kelly go on to confirm that while the Government has provided "an additional £1bn of funding for elective recovery in 2021/22," NHS England bureaucrats have yet to work out how to spend it:

"In the new year we will set out more details of how we will target this funding".

Private beds

A good lump of this money is set to go to private hospitals. The letter stresses the importance of "maximising use of the independent sector," as well as use of "funded additional facilities such as the Nightingale Hospitals" (most of which have not been staffed or more than fractionally utilised).

They also urge "Timely and safe discharge … making full use of hospices" – two thirds of which were facing financial crisis and redundancies last October and pleading in vain for extra government funding.

With no corresponding focus on maximising use of NHS beds, the emphasis on using private hospitals (now coyly referred to as "IS providers") emerges again with the revelation that:

"… we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. ….

"If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team."

The letter also requires all CCGs and trusts to

- have a senior responsible officer to lead the EU/UK transition work,
- review maternity services against the twelve urgent clinical priorities of the Ockenden Review (of Shrewsbury and Telford);
- appoint a board-level executive lead to prepare system based recovery plans and outpatient transformation;
- audit progress against eight urgent actions to tackle health inequalities as set out in a July 31 letter;
- and to top it all, systems and organisations – working flat out to treat Covid patients and deal with winter pressures – "should start to develop plans for how Covid19 costs can be reduced and eliminated once we start to exit the pandemic."

Our sympathies to the NHS managers and other staff whose Christmas was ruined by stress as a result of this letter.

■ This article is shortened from an original in The Lowdown.

Private hospitals "taking the piss" – say NHS medical directors

Claims by Matt Hancock, Simon Stevens and other senior figures from NHS England that the private hospital sector should be regarded as a permanent "partner" of the NHS after the block booking of private beds this year have been exposed as deluded.

Far from seeing their role as complementing the NHS, and delivering care for NHS patients at cost, it's clear that private hospitals' first and only priority is profit – even if it means turning their backs on NHS cancer patients whose treatment is held up by the second wave of Covid-19.

Some are openly hoping that the cancer and cardiac patients will go private to avoid delays.

According to the ***Health Service Journal***, the medical directors of London's leading hospital trusts have been "incensed" that the independent sector and the doctors working in it were performing non-urgent work in the private sector while all but the most urgent elective activity is being postponed in the NHS in London.

They expressed the view the sector needed to be "shamed" into providing more help, rather than "once again taking the piss and walking off with the money."

"Historic partnership"

Just before Christmas Healthcare Markets magazine was boasting that almost two million operations, scans, consultations and chemotherapy sessions had been delivered under the

"historic partnership" between the NHS and independent hospitals, with the sector and its workforce "playing an essential role in ensuring vital treatment, notably cancer care, could continue during the pandemic."

"It is in the interests of the NHS and the nation as a whole to have a strong independent health sector in the UK."

However it also let slip that the agenda of the public and private sectors are by no means the same:

"with NHS waiting times rising at an exponential rate, the full might of the independent health sector and its workforce is going to be needed not only in supporting the NHS in getting waiting lists down, but also treating the many more people who will be looking to privately fund their healthcare in a bid to access faster treatment."

An earlier exclusive article in the HSJ revealed that three major London private hospitals, US-owned HCA, The London Clinic and the Cromwell Hospital have pulled out of any renewed contracts to treat NHS patients – because the fees on offer were not high enough.

Rules rejected

The private hospitals were unwilling to return to rules under the first block-booking of beds that ensured low-priority private patients were not treated ahead of NHS patients – including cancer patients – who needed surgery urgently.

HCA UK chief executive John Reay said while the company was keen to "continue partnering with the NHS," its priority was restarting activity for its core private patient base, where demand was again increasing: "Reay believes the number of patients requiring treatment, particularly for cancer and cardiac care, means HCA's hospitals will be 'full and busy'."

The private hospital sector was bailed out of a financial hole by NHS England in the spring as their regular business collapsed: the NHS block-booking effectively paid for use and covered all of the overhead costs of up to 8,000 private beds – although only a fraction of this number was ever actually used.

Unused beds

By June, as Treasury officials apparently blocked NHS England proposals for an extravagant £5 billion contract for use of private beds through to April 2021, consultants in the private sector were telling the media that the hospitals have been empty and doctors have been "twiddling their thumbs".

In July the Federation of Independent Practitioner Organisations was complaining of customer unrest: "Medical insurance risks becoming worthless because of the difficulties policyholders face getting treatment since the NHS took over the running of private hospitals."

Now, according to the Financial Times, private firms are looking forward to a "coronavirus bounce" combining increased NHS contracts and self-pay patients. A new fixed-term three-month contract will guarantee volumes of NHS-funded work for 14 private hospital providers until March.

Meanwhile the IHPN has successfully ensured that those working in the independent health sector would benefit from the Home Office's visa extension for healthcare workers, with parity of access to vital Covid testing, as well as the forthcoming Covid-19 vaccine for healthcare professionals working in the sector.

And from March more than 90 private providers, including the two biggest, Spire and privately owned Circle, have signed up to a 4-year £10bn framework deal with NHS England, which aims to clear a huge backlog of procedures postponed because of the pandemic … while thousands of NHS beds stand empty.

■ This article is updated and amended from an original in The Lowdown.

Union battles IN BRIEF

Norfolk & Norwich

About 50 maintenance staff at the Norfolk and Norwich University Hospital have accepted an inflation-busting 4.5 per cent pay increase for 2020-2021.

Unite the union, which represents the majority of the electricians and plumbers working on the outsourced Serco contract, said the award went 'some way' to reducing the pay gap with directly employed NHS estates staff at other Norfolk hospitals.

Security strike

Security staff at the Royal Berkshire Hospital in Reading, locked in a 'David and Goliath' pay battle with their employer, will be striking for 20 days during January and February seeking a pay increase to £12 an hour for security officers and £13.00 an hour for security supervisors.

The 23 security guards members of Unite, are striking from 07.00 on Monday 4 January over the failure of their employer Kingdom Services Group Ltd, part of a global organisation with a £100 million turnover, to make a decent pay offer for 2020. Their strike action will end at 19.00 on Friday 12 February.

They have already taken five days of strike action which ended on Friday (18 December).

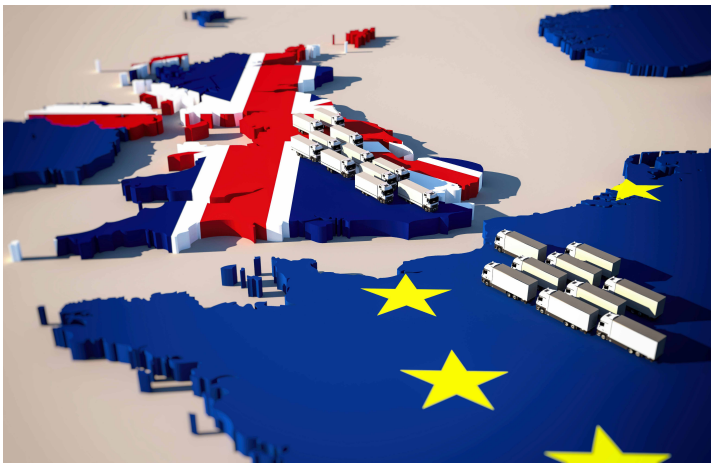
Pharmacists find winning formula

PDAU, the pharmacists' union, are now recognised in several hospital wholly owned subsidiary outpatient pharmacies after Boots UK did not renew their contracts and pharmacy staff were TUPE transferred.

The union have called for staff in the outpatient pharmacies to be moved onto NHS Agenda for Change contracts like their colleagues in the main hospital pharmacy departments at these trusts and have already aligned future annual pay review dates.

■ In December, PDAU secured recognition and negotiating rights for all GP Federations "Federations" set up by groups of GP practices for the purpose of employing the pharmacist personnel in Northern Ireland.

NHS and social care will be counting the cost of Brexit deal



The last-minute 'night before Christmas' trade deal with the EU signed by Boris Johnson and endorsed by Conservatives and most Labour MPs in a Commons vote on December 30 avoids some of the very worst feared outcomes of a no-deal exit, but will have an impact on the NHS and social care.

The deal that has been signed avoids the "reasonable worst case scenario" if no deal were signed, which included warnings of public disorder, shortages of fuel, rising food prices, and initial reductions of up to 40% in supplies of medicines and medical products.

However delays are still likely and the NHS is certain to be landed with some of the extra £7.5 billion in administrative costs that the HMRC has predicted would be incurred as a result of Britain leaving the Customs Union, triggering a near-fivefold increase in numbers of customs declarations.

Overseas recruitment

The other problem that has been flagged up since Priti Patel first published her reactionary "points based" system to restrict immigration is that while most health care staff should meet the entry criteria, staff who look after older people in care homes won't, and can no longer be recruited from overseas to work in the UK, as they earn below a £25,600 threshold for skilled workers.

The axing of freedom of movement will therefore have its most brutal impact on the care for frail elderly residents in increasingly under-staffed care homes, especially in parts of south east England where up to 30% of care staff have been recruited from EU countries.

The Nuffield Trust's programme lead Mark Dayan, has warned that the new rules would hit social care especially hard, noting that the problem is of the British government's own making.

An additional longer term problem highlighted by the NHS Confederation is that the Brexit deal ends mutual recognition of professional qualifications.

While the UK (in need of professional staff) has unilaterally decided to continue to recognise EEA qualifications for up to two years, the EU has made no equivalent concession.

This will limit British-trained professionals from developing their skills and research by taking up posts in EU countries.

Bureaucracy

Health staff who are EU nationals now face more bureaucracy if they want to work in the NHS. The government summary of the deal makes clear that new recruits from the EU will need visas to work here and have to pay the immigration health surcharge on top of regular taxes.

Barts Health, one of the biggest NHS trusts, has more than 1,700 staff from the remaining countries of the European Economic Area. Barts issued a statement on December 31, warning that the end of the transitional period means all EU citizens who were resident in the UK by 31 December 2020 will need to apply to the EU Settlement Scheme (EUSS) to continue to live, work and study by 30 June 2021:

"This also applies to their family members including children and non-EU citizens. You may be asked to provide relevant documents to confirm your status in the UK in order to establish your entitlement to free NHS hospital care."

With three quarters of the medicines used by the NHS and half of all medical devices for the UK coming from the EU, many experts, industry leaders, health bosses and members of the Government, have acknowledged that disruption at the border will be an inevitable consequence of leaving the EU.

The trade deal only covers goods, not services, leaving doubts over many high technology products such as medical scanners which are supplied as a bundle with operating or maintenance contracts.

Any disruption of maintenance or supply of components could threaten the ability of hospitals to deliver care.

The NHS Confederation warns that the UK "will not normally have access to EU databases and will not retain membership of the European Centre for Disease Prevention and Control (ECDC)."

Medicines agency

The government also decided to pull out of the European Medicines Agency (EMA) which used to be based in London: as of last February no one representing, appointed by or nominated by the UK can participate in any EMA scientific-committee or working-party meetings, or in the Agency's Management Board.

NHS Confederation Chief Executive Danny Mortimer summed up:

"NHS leaders will be flooded with new rules, guidance and information and be required to make significant adjustments at breakneck speed – all while dealing with unprecedented COVID-19 and winter pressures.

Whilst the preparations for the NHS are as good as can be, the circumstances could not possibly be worse."

■ Edited from a longer article in ***The Lowdown***

St Helier Hospital in Carshalton dates back to 1930s – but smaller replacement could be unaffordable

New hospital plans in chaos as costs rise

One of the six funded new hospital developments has run into predictable financial problems since being given the go-ahead by the Independent Reconfiguration Panel.

The plans, drawn up long before the Covid pandemic, would reduce the **Epsom & St Helier trust** (ESTH) in South West London to just 386 front line acute beds, with the downgrading and downsizing of beds at Epsom and St Helier hospitals, and all acute capacity and specialist work located in a new hospital in Sutton.

However the ESTH Board meeting in January heard that the timeline for the Outline Business Case phase of the Building Your Future Hospital programme is now seen as "very ambitious" and may not provide enough time to develop the design, costing and economic appraisal to the detail required.

In addition, since the submission of the Pre consultation Business Case, there have been significant changes in what needs to be incorporated within the programme, "including COVID design implications, build regulations such as carbon neutral, technology enabling schemes such as EPR and additional optional variants such as Renal."

It's now clear that all of these make the project much more expensive, with the risk that the final design becomes "unaffordable".

Shropshire

The same problem has hit the controversial Future Fit plan in Shropshire to centralise acute hospital services in Shrewsbury and downgrade services in Telford, now renamed the 'Hospital Transformation Programme'.

Shropshire campaigner Gill George said

"This immensely troubled and unpopular programme has been

limping along since November 2013. In the autumn of 2015, the original 'whole system' approach was abandoned when NHS England deemed it unaffordable, and it was replaced with an acute-focused programme.

"Public consultation on this took place over the summer of 2018, at a time when the capital cost of Future Fit was estimated at £312m. The estimated capital cost has slid about. It rose to £498m in a report leaked in December 2019; and it was reported to local MPs by the Trust to have risen to £580m in January 2020 (when the then Trust Chair Ben Reid described the project as 'botched').

"However in July 2020 the cost was said by STP Chair Sir Neil McKay to be £533m.

"The only information available to the public has been via leaks. It's unclear what level of capital funding has been authorised by NHS England and/or the Treasury. An Outline Business Case is now

under development – reportedly via a £6m 'draw down' but it's not clear if it will include every major component – at both sites – that went to public consultation in the summer of 2018."

If the capital is limited to the £312m initially allocated, the big question is whether any funding shortfall will result in a phased or limited implementation of the Future Fit/ Hospital Transformation Programme – and when local people will be told.

Leicester

Similar questions of cost and capacity hang over the planned reconfigurations of hospitals in Leicester, also one of the six funded projects, where a consultation with limited scope for public involvement concluded on December 21.

It's most improbable that the allocated sum of £450m will be anywhere near enough.

Campaigners also remain concerned that the plan is far from Covid-proof, especially since it involves extensive sales of land and buildings, and the promise of additional acute beds is not borne out by the consultation document.

The plan centralises almost all of Leicester's maternity services in a massive new "baby factory" maternity hospital in Leicester Royal Infirmary, handling 11,000 births a year – while the free-standing midwife-led unit at St Mary's faces closure

But perhaps most worrying of all is that the viability of the acute hospital plans hinge on expansion of community-based services – for which there are no detailed plans and no funding available.

Two community hospitals are known to be under threat – but the consultation deliberately separated out the hospital plan from community health, effectively discussing only half the plan.

Trade Bill – press your MP to vote for Lords amendments

The fight is on to persuade as many MPs as possible from all parties to vote for two amendments to the Trade Bill that were passed by the House of Lords at the end of last year.

The first protects our NHS from trade deals (the NHS protection amendment) while the second gives MPs the power to scrutinise trade deals (the Scrutiny Amendment).

Last July Conservative MPs voted against protecting the NHS in trade deals, and all but 12 Conservative MPs voted against giving our elected representatives (MPs) the power to scrutinise trade deals.

Now the House of Lords has passed both amendments MPs will get another opportunity to vote the right way.

The date for the third reading of the Bill in the Lord has not yet been fixed, but it could return to the Commons at any time.

We Own It are campaigning for MPs to sign a pledge to vote for the Scrutiny Amendment: "When the Trade Bill returns to the House of Commons, I PLEDGE to vote for the amendment that gives Members of Parliament the powers to scrutinise trade deals negotiated by the government before they are finalised and signed."

Three Tory MPs are among those who have already done so.

The Keep Our NHS Public Trade Deals Working Group are urging campaigners and trade unionists to keep up the pressure on MPs by writing to the local press to highlight the issues at stake, and the need to support both amendments.

NEXT ISSUE

Our next issue of the monthly bulletin will be February 2021, please get any articles, photos, tip-offs or information to us no later than FEBRUARY 1.

HEALTH CAMPAIGNS TOGETHER #our NHS

"It's vital megalabs have an appropriate skill mix" – IBMS

The professional body representing laboratory staff, the Institute of Biomedical Science (IBMS), has expressed concerns over the plans – revealed to trade unions by Dido Harding – for the first of a network of new mega laboratories, in Leamington Spa, to be contracted out to Medacs, a private recruitment agency.

IBMS president Allan Hall told The Lowdown:

"There is a significant risk that employing 2000 staff at this stage could destabilise the existing NHS and private laboratories currently providing a diagnostic service to the acute and primary care service. We are all "fishing in the same pond" as we try and increase capacity for COVID testing to meet clinical demand.

"We have evidence that recruitment agencies working for the Lighthouse labs have been directly approaching Biomedical Scientists working in the NHS to offer them enhanced salaries to tempt them to leave the NHS.

No experience

"It is a concern that instead of working with the professional bodies and the existing pathology community to explore how these new mass testing labs could be staffed and run as extensions of the existing pathology labs, the government has chosen to engage with a recruitment agency with no pathology experience."

Asked whether it seemed likely that the new mega-lab, unlike the Lighthouse Laboratories, which were set up in parallel with the existing NHS laboratories, would be properly accredited and regulated, Allan Hall replied:

"It is difficult to predict at this stage. There is a glimmer of hope as a meeting took place this month between the IBMS CEO, deputy CEO and representatives from Deloitte who are also closely involved in getting the new mega-labs up and running.

"For the first time they were asking about staffing levels and HCPC registration and expressed the desire that the new labs should attain IBMS training lab approval, but were advised this was unlikely to be achievable in the short to medium term.

"It is vital that these labs have an appropriate skill mix and include significant numbers of HCPC registered Biomedical and Clinical Scientists. We would not allow unregistered staff to run care in clinical settings such as medicine, nursing or radiography – why are labs being viewed as "different"?

"We have professional registration in place for a reason – to protect the public."

"We have a high quality diagnostic pathology service in the NHS – it is difficult to see at this stage what the Lighthouse labs can offer once the need for COVID testing has declined."

■ Edited from a longer article in ***The Lowdown***

Cashing in on COVID

The new wave of privatisation in the NHS – and how to stop it

The NHS faces its most serious threat ever as ministers use the cover of the pandemic to push through far-reaching changes.

- **Billions** have been frittered away on inefficient and ineffective private contractors rather than investing in the NHS and public health
- Huge and continuing scandals in the allocation of **PPE contracts** to "fast-tracked" neighbours and cronies of ministers
- Private **management consultants** paid up to £7,000 per day – and steering investment to contractors, not the NHS
- **£12bn** spent on privatised **Test and trace** systems that are a byword for failure
- Tens of millions wasted on new 'lighthouse' **laboratories** and fully privatised 'megalabs' that bypass NHS laboratories
- Billions spent hiring **private hospitals**, with up to **£10 billion** more in next 4 years while thousands of NHS beds lie empty.

Unprecedented attacks need new ways of fighting back: join our

Online CONFERENCE

Thursday February 25

6.30-8.30pm

- ☐ Book now to confirm your place
- ☐ Every delegate will receive a **Campaign Resource Pack** with key facts, figures, explanations and campaigning ideas
- ☐ Help develop the new arguments and new campaigns we need if we are to win!

Book your place now and keep the date: full details in early January

https://www.eventbrite.co.uk/e/the-pandemic-and-privatisation-tickets-133213835167

Early bookings show need for privatisation conference

As this issue of HCT monthly news is completed over 150 people have already signed up for **more details** of the conference on **The Pandemic and Privatisation**, to be held **ONLINE** on **February 25, 6.30-8.30pm.**

The conference has been called by Health Campaigns Together, working with the NHS Support Federation (The Lowdown), Keep Our NHS Public, and by the health unions UNISON, Unite, GMB and PDA (Pharmacists') union. More details will be announced soon.

The focus will be on the scale and impact of the new privatisation carried out under the cover of Covid – but also crucially on the new ways we need to work to expose the truth to a poorly-informed public, in order to build a powerful campaign in defence of the NHS as a public service.

The pandemic has been a goldmine for private contractors and management consultants.

Huge sums that could have been wisely spent expanding and adapting NHS services and public health networks as assets for the future were instead frittered away on failed contracts with Serco, Sitel, Deloitte.

As stories in this issue show, billions more are being squandered on private hospital beds and contracted services that could undermine the future of the NHS.

How can health unions and campaigners work together to develop the right publicity and information to show the folly and expose the waste and inefficiency of privatisation and outsourcing?

Book your place **HERE**

Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an alliance of organisations. We ask organisations that want to support us to make a financial contribution to facilitate the future development of joint campaigning. WE WELCOME SUPPORT FROM:

- **TRADE UNION** organisations – whether they representing workers in or outside the NHS – at national, regional or local level
- local national NHS CAMPAIGNS opposing cuts & privatisation
- pressure groups defending specific services and the NHS,
- pensioners' organisations
- political parties – national, regional or local

The guideline scale of annual contributions we are seeking is:

- **£500** for a national trade union,
- **£300** for a smaller national, or regional trade union organisation
- **£50** minimum from other supporting organisations.

NB If any of these amounts is an obstacle to supporting Health Campaigns Together, please contact us to discuss.

You can sign up online, and pay by card, bank transfer or by cheque – check it out at *https://healthcampaignstogether.com/joinus.php*

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