THE lowdown

Health news, analysis and campaigns.
NUMBER 7,
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Informing, alerting and empowering NHS staff and campaigners

Both main parties call to bring NHS catering back in-house

The listeria sandwich scandal prompted even Health Secretary Matt Hancock to call publicly for NHS managers to end their dependence on external private suppliers and bring cooking back in house, with hospitals once again employing their own chefs and relying on quality local food.

That is the way it used to be before Margaret Thatcher's government artificially separated "hotel services" from the rest of the hospital and subjected cleaning, catering and laundry services in particular to competitive tendering.

Hancock, apparently oblivious to his own party's role in undermining standards of hospital food, called for a "root and branch review," noting that "dozens of hospital trusts" had improved food quality by bringing catering back in house.

Jon Ashworth

Catering was inhouse before Margaret Thatcher's government artificially separated out "hotel services"

Hancock also appeared blissfully unaware his shadow opposite number, Jonathan Ashworth, had called for precisely these changes, along with measures to enforce higher food standards, more than a year earlier. He said:

"Unlike schools and prisons there are no mandatory minimum requirements for hospital meals, so the next Labour government will substantially increase investment in our NHS to improve patient care including providing the nutritious meals patients deserve."

■ See pages 8-9

Image: Andy Stenning/Daily Mirror

Bradford staff go for second week of strikes

UNISON members at Bradford Hospital whose lively week-long strike has failed to secure any retreat from management could be set for further action.

The union if fighting to keep support staff 100% NHS, and against Trust plans to set up a tax-dodging "Wholly owned company,"

A letter from the branch quoted in the local Telegraph and Argus states: "Following a week of solid industrial action by estates and facility staff, the Trust has refused to cease or even postpone its plans to transfer staff into the private company Bradford facility services.

"The Trust stated in the meeting that they wished to look into ways of giving more assurance around terms and conditions but accepted that as yet they could not make guarantees that would legally prevent future changes to terms by lawfully terminating contracts and offering inferior ones.

"Unison informed the Trust that it will now seek to take more sustained action in view of the Trust's response.

"We are therefore in the process of issuing a new industrial action notice, with aim of taking a continuing and indefinite programme of action subject to regular democratic members meetings to ensure there is a broad consensus.

"In the meantime we are in the process of taking steps to ensure the strike is financially supported across the union and labour movement as a whole."

Please give solidarity, and sign the petition: https://t.co/36IOCztADi

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Cambridge and Peterborough cuts home in on community services

This week Cambridgeshire and Peterborough CCG announced a first round of £2.8 million in spending cuts affecting a range of services including brain injury rehabilitation, ophthalmology service, and dermatology with a further £1.3m expected later in the year.

It looks like community services will take the largest hit, with an urgent response team (JET) that supports over-65s with long-term conditions in their homes under threat.

The JET team responds within 2 to 4 hours when patients feel unwell, carrying out an initial assessment and developing care plans with patients and their GPs to prevent hospital admission.

An NHS Improvement report on JET revealed that the team had an admission avoidance rate of over 70%, preventing around 7000 hospital admissions a year,

Despite its plaudits Jet is part of cuts plan being drawn up by Cambridgeshire and Peterborough CCG in an attempt to turnaround a £75 million deficit and overspending of around £1 million a week.

The scope of the CCG's planned cuts are likely to hit community non-emergency transport services, stroke patients and carers support charities, plus further restrictions on IVF treatment according to Board papers.

Last month, health minister Jackie-Doyle Price wrote to Cambridgeshire and Peterborough CCG, amongst others, condemning their rationing of IVF treatment. Since 2017, the CCG has suspended its IVF treatment programme contributing to the emerging postcode lottery for this service.

The CCG blames a lack of funding and disparities in the way government money is shared out, pointing out that it is the third lowest funded CCG in the country, with others receiving up to £350 per person more.

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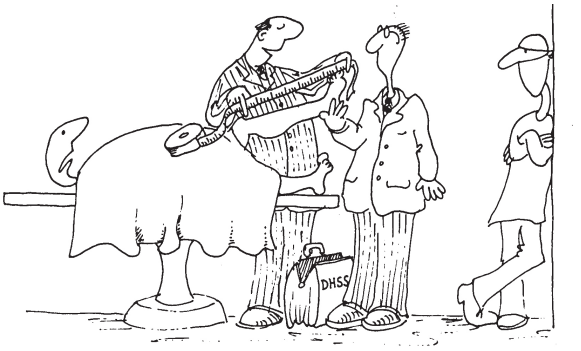


Jo Rust, regional organiser for UNISON, who took part in a protest as the CCG considered its plan, told the ***Peterborough Telegraph*** that she had some sympathy for the CCG's argument that they are underfunded, but added that the cuts were worse than they looked, and warned that some were going "beneath the radar" as they were not affecting hospital trusts directly.

● We will follow this story and similar cuts elsewhere in future issues of ***The Lowdown*** after the summer break.

Privatising public involvement

While Matt Hancock claims there will be no privatisation on his watch, his own Department for Health and Social Care is proceeding to further privatise even the process of patient and public involvement.

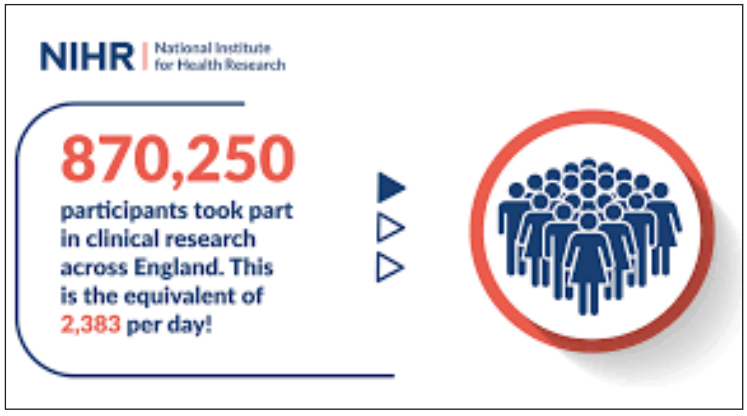
The National Institute for Health Research (NIHR) is merging its INVOLVE function with its Dissemination Centre, and the contract to run the new centre from April 2020 was put out to tender by the DHSC, and won by LGC, a once publicly owned body that was privatised by John Major's government and has since been bought up by a US-based private equity giant KKR.

LGC is still keen to trace its origins back to 1842 when the Laboratory of the Board of Excise was founded in the City of London to regulate the adulteration of tobacco which was prohibited under the Pure Tobacco Act.

Industrial vision

This developed into a wider-ranging Laboratory of the Government Chemist, but was eventually flogged off in 1996 and renamed LGC, and was subsequently bought up by KKR, which describes itself as a global investment firm 'with an industrial vision'.

The Dissemination Centre had already been partially privatised, run in partnership between Southampton University's Wessex Institute and another private outfit, Bazian, which was taken over in 2013 by the Economist Intelligence Unit.



The INVOLVE function was set up to promote patient and public involvement (PPI) in NIHR-funded research, and has also been hosted by the Wessex Institute, but until now without a private partner.

While the decision now to hand both operations over to LGC on a five year contract offers the possibility of some juicy data for LGC and its private equity owners, it does raise the question of what possible benefit the DHSC might argue this latest privatisation could deliver to the public.

Successful lift off for the Lowdown – help us take the next step

Thank you for your interest and support for the ***Lowdown***. In just a few months you have helped us create a regular publication that provides analysis and news about what's really happening in the NHS and crucially, connects our readers with campaign actions to help change the issues that we all care about.

We now need your support to sponsor our journalists and researchers to step up this important work.

Please help us with a donation today.

Through the ***Lowdown***, a growing community of NHS supporters is being kept up to date and joining in with local and national campaigning. Already information shared by our readers has helped us to investigate some shocking issues.

■ Plans to privatise a world renowned NHS PET-CT scanner service in Oxford. Ministers say they are turning away from outsourcing, but our research keeps finding evidence to contradict this and we will not let this issue go.

■ Debt-ridden NHS trusts are cutting their NHS treatments and urging patients to go private in NHS pay beds. Our team is collecting evidence from across the country to fuel campaigns to keep our NHS comprehensive.

■ Some mental health services are at breaking point from understaffing and cuts. Tragically patients are dying because care does not reach them soon enough. Children are waiting too long and often travelling hundreds of miles for care. We have been looking at the reasons why, and how we can change it.

These issues are pressing, causing huge and unnecessary suffering. The NHS is too often struggling to provide the standards of care that it wants to.

However, we believe this can change as the evidence points to the failings of key policies on health planning, staffing and capital improvement and not the core ideas behind the NHS.

We need your support to help us to investigate and publicise these crucial issues. If you can, please make a donation today.

By sponsoring our researchers and journalists you will help us to alert NHS supporters across the country, challenge our politicians and put the focus on the solutions, supporting NHS staff in improving the service.

It is often hard for NHS supporters, trade unionists and staff members to keep pace with the issues and yet the NHS relies on our support. *The Lowdown* aims to make it easier, summarising the news, providing regular explainers and analysis. This is a new service that we want to keep building.

We aim to provide people with the information tools they need to negotiate, communicate, campaign and lobby in defence of the NHS.

If you can, support us with a donation, but you can also help by sharing our content and by sending us information about what's happening in your local NHS.

We are off now for a short break in August and to spend some time recruiting new contributors and getting some feedback to improve the ***Lowdown***. We'll be back at the beginning of September. In the meantime, thank you for all your support.

Best wishes from Paul, John, Sylvia, Molly and all our Lowdown contributors

We aim to provide people with the information tools they need to negotiate, campaign and lobby in defence of the NHS.

In our first year we will:

- establish a regular one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally.

We have covered the battles against Wholly Owned Companies, such as Birmingham and Solihull (above)

CCG springs a leak in choppy North West London waters

John Lister

Signs of dislocation and chaos continue in North West London after the flagship "Shaping a Healthier Future" project – which had threatened to close A&E and acute services at Ealing and Charing Cross Hospitals – was belatedly scrapped by Matt Hancock in April.

The Clinical Commissioning Groups remain mired in debt, entering 2019/20 with an underlying deficit of £99.6m, while many of the main NHS and foundation trusts are also deep in the red.

A leaked "crib sheet" drawn up to supply senior managers with prepared answers to difficult questions about the collapse of the plan, which wasted over £230m, has revealed that even NW London communications supremo Rory Hegarty has been unable to suggest convincing replies to some questions, such as **"How will you change the way you make decisions in future to ensure millions more pounds of taxpayers money isn't wasted?"**

The crib sheet is consistent in offering no apology for the fiasco, and in giving a flat "No" to the question on whether anyone responsible will resign.

Citizens Panel

Instead the management team that so conspicuously failed to consult or engage with affected communities or boroughs in during most of the 7 wasted years of the project have been trying this year to reinvent themselves as advocates of a new "Citizens' Panel" to "to support, comment on and develop our thinking on a range of healthcare issues".

When this idea was first floated at the end of February 2019 it was proposed as an enormous 4,000-strong body – 80 times larger than the NHS Assembly established in the spring.

Where the Panel might meet or how it might function was not explained.

However it seems that senior managers have already got cold feet over this idea. By May 2019, plans for a single Clinical Commissioning Group to cover the 2.2 million population of NW London across 8 boroughs claimed less ambitiously: "we are putting in place a 3,000-strong Citizens' Panel across NW London – a demographically representative group from which we will regularly seek feedback."

Campaigners point out that if the current rate of shrinkage (25% in 4 months) continues, mathematically there will be no membership left for the 'panel' by February 2020. Perhaps this is why nobody has sent out any invitations for people to join it, and no dates or venues have been announced for meetings?

Far from pulling the team together, the awayday event seems to have underlined the divide between staff and senior managers

Away Day

Meanwhile efforts to engage with staff in the 8 CCGs which are set to be streamlined down to just one have proved less than a roaring success.

Details have been leaked of an 'away day' which over 500 staff were required to attend, where management – (perhaps unwisely) arranged for staff to be able to text or email live feedback and questions on their presentations.

Although only the feedback has been leaked, it appears few if any of the questions raised in this way were answered by the panel on the platform.

Indeed far from pulling the team together, the event seems to have underlined the divide between staff and senior management, headed up by NW London 'Accountable Officer' Mark Easton, who appears to have adopted a prudently low profile as the event went belly-up, prompting repeated questions of why he was not answering points raised.

Management read out tedious and previously scripted answers to the questions they imagined staff might ask, but failed to answer the most commonly asked questions – on how many jobs would be lost in the process of merging the CCGs, and what terms would be offered to staff.

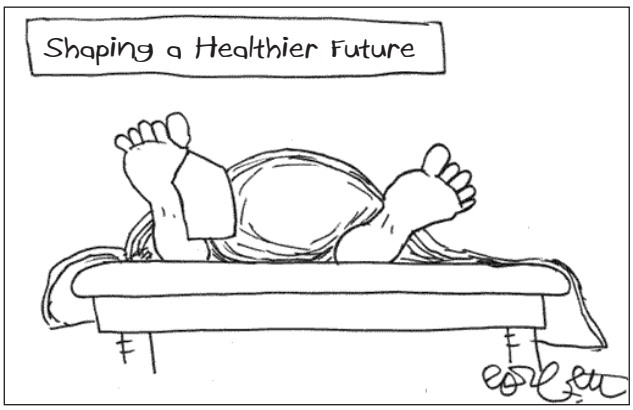
Nor did they respond to any of the questions on the collapse of the SaHF project and the money wasted on it.

Frustration

Many of the questions and comments highlighted staff frustration and anger at inflated salaries paid to management consultants and "interim" staff, some of whom had stayed on for months or years, as well as fears that job losses will be largely among lower ranks of staff with those at the top clinging on, anger over bullying, and a general sense of lack of management competence: "Why are there so many Project Managers paid ridiculous amounts of money who don't deliver their projects successfully but then get assigned to another project?"

The tenor of the feedback to this morale-raising exercise suggests a worrying level of cynicism and disaffection among the CCG staff who are supposed to plan and commission health care in NW London.

It seems that rather than draw up plans for an imaginary Citizens Panel of thousands, and creating platforms for them to rehearse their set speeches, NHS bosses would do better to start by listening to their own staff and responding to the questions they are actually asking.



Early closure for stroke unit – or is it just as planned?

John Lister

The premature closure of stroke services at Tunbridge Wells in September rather than the scheduled date of next March was one of the most predictable outcomes of a massive reorganisation of services that has blighted four threatened stroke units in Kent.

In addition to Tunbridge Wells, stroke services are to be axed in Medway, QEQM Hospital in Margate; and the "temporary" closure of stroke care at Kent & Canterbury Hospital is to be made permanent – all to make way for just three new specialist "Hyper Acute Stroke Units" in Maidstone, Dartford and Ashford, which are not set to come on stream until March.

The Maidstone and Tunbridge Wells trust has now admitted to Kent County Council's scrutiny committee that from next month the thrombolysis service at Tunbridge Wells can only be staffed 9-5 Monday to Friday and on some weekends.

The Kent committee has repeatedly failed to take any action to challenge the plan, despite the fact that the three remaining HASUs to cover the whole of Kent will mean marathon journeys from many areas, with the potential for heavy pressure on the reduced number of beds.

Medway council has highlighted warnings from the Clinical Senate on the likely pressures on the centralised stroke services from the increasing proportion of elderly people in Kent and Medway, together with the increase in the overall population.

Campaigners point out that some Kent services, including the potentially doomed QEQM in Margate, are already outperforming London on access to imaging within an hour of admission.

It was always going to be hard to recruit staff to a doomed unit. The Business Case itself pointed out the danger that one or more of the existing units could close even before the new services come on stream, or as they put it: "the risk of closing units becoming unsustainable due to an inability to retain and recruit staff".

Campaigners will feel quite reasonably that this "risk" was so foreseeable it is effectively part of the plan, which is now closing units before any of the proposed specialist units are complete. This looks like orchestrated decline rather than a plan.

Medway Council has referred the plans to the health and social care secretary and the local Save Our NHS in Kent (SONIK) campaign is among those planning a judicial review.

Towards a two-tier NHS

The Health Service Journal has revealed that some NHS hospital trusts are allowing patients to pay privately to have procedures which are banned or tightly restricted as a result of NHS England guidance last year.

A "relatively narrow" initial list of 17 treatments to which access would be restricted or in four cases virtually banned was published last July: a few of the treatments were declared to be ineffective, although most of them were still to be available – as long as the CCG gave prior approval.

The list became a rigid rule on April 1, but NHSE made clear from the start their plan was to "rapidly expand" beyond the initial list, to a "much wider, ongoing programme" of restricting access to NHS-funded treatment.

Many CCGs have moved rapidly – apparently with the consent of NHS England, which has not intervened – to draw up increasingly lengthy lists of dozens of excluded treatments, leaving patients a choice of going private or going without.

This resulted in the recent scandal when Warrington and Halton hospitals trust attempted to cash in on the long local list of exclusions, which includes hip and knee replacement and cataract operations, and offer them privately to patients able to pay thousands of pounds, creating a 2-tier NHS.

The trust retreated rapidly when its plan was exposed by the Daily Mirror.

The HSJ points out that many trusts have looked to expand private units to generate income in recent years. Some are seeking to tap into the fastest-growing sector of private medicine, the "self-pay" treatment of patients who do not have private health insurance.

According to market analysts Laing & Buisson self pay surgery and treatment accounted for £1.1 billion of revenue for independent hospitals and clinics in 2017, up 9% on the previous year, and more than double the reported £493 million revenue in 2013. The NHS, too, continues to be an important provider of self-pay treatment.

Laing & Buisson argue that key drivers for this market include "the cancellation of elective procedures owing to pressure created by non-elective admissions in the NHS … coupled with increasingly restrictive funding criteria for elective procedures on the NHS, especially in orthopaedics, ophthalmology, gastroenterology, gynaecology and urology."

Appeal to governors to stop PET privatisation

Amid fears that a contract is about to be signed behind closed doors, Oxfordshire Keep Our NHS Public has written to all 27 members of the Council of Governors of Oxford University Hospitals NHS Foundation Trust, calling on them to halt the privatisation of the PET-CT scanning service at the Churchill hospital in Oxford, and to back the referral of the matter by the county's Joint Health Overview and Scrutiny Committee to the Secretary of State for Health.

Their letter points out that the clinicians at the Churchill have grave concerns about the impact of the proposed privatisation on the quality of service for patients, but also notes that

"legal steps by the Trust to oppose the imposition of privatisation of the PET-CT scanning services were in place in July 2018" before "they were suddenly dropped following an intervention by the then chair of the NHS England, Lord Prior."

The letter also notes campaigners' concerns over the failure of OUH's chief executive Bruno Holthof to stand by the clinicians, who are refusing to join "partnership talks" as a result of their concerns over patient safety. And it adds:

"We understand that you may not have been fully informed of these matters in a timely way in the past."

Chronic failure of Norfolk & Suffolk trust board, CQ

Mental health trust is still unsafe

John Lister

The Norfolk and Suffolk Foundation Trust (NSFT) is England's worst performing mental health trust, and remains bogged down in 'special measures,' although these measures have done nothing to address the deeply flawed management regime, or prevent it receiving a third 'inadequate' rating from the CQC last November, and again being branded as unsafe.

The chronic failure of the trust comes despite (or possibly as a result of) it having a massively inflated proportion of managers: and this is getting worse.

In 2017 the local ***Eastern Daily Press*** (EDP) revealed that while the number of doctors and qualified nurses at NSFT had fallen by more than twenty per cent over the last five years as a result of cutbacks, the number of managers had risen by more than fifty per cent.

Angry campaigners have pointed out "NSFT has 67 per cent more managers than the Norfolk and Norwich, a university teaching hospital with three times the turnover, nearly twice as many qualified nurses and more than five times as many doctors. …. NSFT employs 1.3 doctors for every manager, while the Norfolk and Norwich employs 12.25 doctors for every manager."

However repeated CQC reports since 2013 show clearly that this proliferation of managers are not delivering results that justify the resources they consume.

The BBC has reported that numbers of disruptive out of area placements of mental health patients for whom there are no local beds have trebled in the past 12 months, with some Norfolk and Suffolk NHS Foundation Trust patients are being cared for hundreds of miles away. The number of bed days for out-of-area placements in April 2019 was 1,911, three times the April 2018 total.

"The system is broken. We [the police] are filling the gap in mental health services that do not really exist."

Steve Adams Eastern Daily Press

Melt down

Campaigners argue that the beds crisis has been caused by a meltdown in community services, and the closure of more than 140 beds by the mental health as part of the disastrous 'radical restructure' in 2013 aimed at cutting spending by a massive 20%.

"Two of the three city adult community teams have been closed to routine work due to lack of staff.

"Nurses carrying caseloads of 60+ who routinely work until seven o'clock in the evening are being followed around by expensive management consultants to see how they spend their time."

An EDP report this month on their findings from a Freedom of Information request reveals Norfolk police are now dealing with an extra 10,000 mental health incidents each year compared with 2014, with over 6,000 a year coming through emergency 999 calls.

Andy Symonds, chairman of the Norfolk Police Federation, told the EDP: "The system is broken. We are filling the gap in mental health services that do not really exist."

Earlier this year an EDP Freedom of Information request revealed people in Norfolk had been detained in police stations for more than 40 hours awaiting assessment or transfer to hospital.

CQC reports

According to the most recent CQC reports, high staff turnover, vacancies, staff away on courses and sickness all contributed to an unmanageably high case load for staff at the Ipswich home treatment team, juggling the needs of 50 patients.

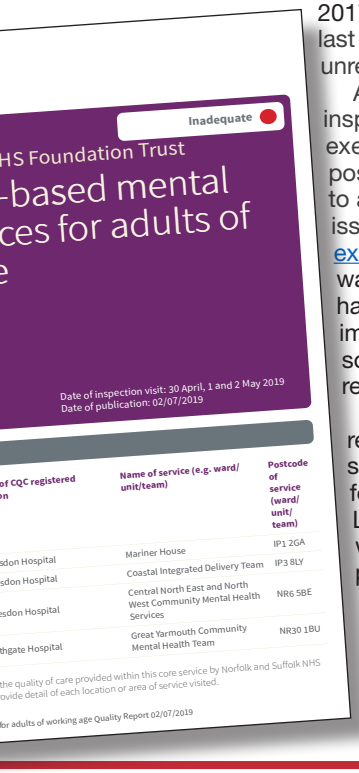
QC and CCGs

Not surprisingly this care was care that was "variable and at times poor" said the CQC after an unannounced inspection.

The inspectors were told that in Norwich the crisis and home treatment team was not consistent in providing safe care, and that staff failing to visit patients as planned was a "daily occurrence".

A separate unannounced inspection of the trust's community-based mental health services for adults also rated it inadequate.

The trust was rated inadequate in the summer of 2017, and an interim inspection last August raised significant unresolved concerns.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the quality of care provided within this core service by Norfolk and Suffolk NHS
ovide detail of each location or area of service visited.
or adults of working age Quality Report 02/07/2019

After each of these inspections the current chief executive has tried to find positives, while clearly failing to address the underlying issues. Last August, then chief executive Antek Lejk said it was "heartening" the report had acknowledged the trust's improvements, but insisted some issues "cannot be resolved overnight."

Six months later having repeatedly failed to resolve the same problems he departed for a senior post at the East London Foundation Trust, with a generous severance package.

Campaigners have been critical of what they see as ineffective CQC intervention over the five years of more since serious concerns were flagged up in 2014.

"We find it incredible that providing care to this number of people, with 24% fewer staff can be done in such a way that does not affect the quality or safety of patient care."

It's clear services have been struggling as a result of staff shortages and under-funding by CCGs, but things have been made much worse by consistently poor senior management which redesigned services in 2013 as a response to a 20% cut in its budget, cutting staff and frontline teams. In four of the following five years there were further cuts in funding.

Special measures

In 2017, having failed to address serious concerns raised by the CQC three years earlier, NSFT was placed again in special measures, after a previous spell from 2015-2016, with the CQC again calling for a host of improvements.

CQC's chief inspector of hospitals Ted Baker said:

"It is extremely disappointing that on our return to NSFT we found the board had failed to address a number of serious concerns. The trust leadership... must ensure it takes robust action to ensure improvements are made and we will continue to monitor the trust closely."

Six years ago officers of the UNISON branch covering the Trust wrote to the joint Health Oversight and Scrutiny Committee to express their concerns over the planned cutbacks and their impact.

They warned that

"Whether you euphemistically call it "Radical Pathway Redesign" or "Service Strategy" the reality is that this is a significant cut to local mental health services, and should be described as such. To not do so causes confusion and ambiguity in the minds of the public."

UNISON noted that the proposed reduction of 502 whole time equivalent staff represented a reduction in 24% of front line clinical staff, so that the same number of patients would be seen by this 24% reduced clinical workforce. They went on:

"We find it incredible that providing care to this number of people, with 24% fewer staff can be done in such a way that does not affect the quality or safety of patient care. There is no evidence that teams or clinicians currently have 24% spare capacity, or that clinicians' time and skills are underutilised."

Risk register

UNISON also warned that the risk register for the cuts was inadequate, and not sufficiently up to date, and suggested the HOSC request to see the risk register, and any plans in place to mitigate against gaps in service provision and risks. They endorsed the concerns raised by both the RCN and BMA that the proposed measures for monitoring the risk of these changes focuses too heavily on "safety" rather than "quality".

Nine months later, early in 2014 the Campaign to save Mental Health Services in Norfolk & Suffolk also issued a detailed call for the HOSC to press for a change of course, asking What has gone wrong with the radical redesign?

Sadly all this prescient good sense went unheeded by councillors, CCGs and a trust board seemingly intent upon multiplying highly-paid management jobs at the expense of front line care.

The latest failure is therefore a combined failure of trust board, along with a proven failure of CQC special measures to make NSFT services safe, along with the chronic failure of local commissioners to allocate adequate resources to mental health services, and of governments since 2010 to provide adequate funding for the NHS.

How much longer will the agony go on for mental health patients in Norfolk and Suffolk?

Hungry for action: the long fight to improve hospital food

John Lister

In recent years celebrity chef James Martin has led the most determined attempt to get hospitals sourcing, preparing and serving fresh, locally produced food for patients, and for staff.

Unlike many of the expensive gimmicks that had fruitlessly spent up to £50m under New Labour, including attempts by top chefs and by Lloyd Grossman to introduce unrealistic new menus from top down, Martin focused on the basics, reopening or making much better use of what kitchen facilities were available, and working with staff to find viable solutions.

However Martin also worked to debunk some of the false assumptions which made hospital trusts opt for buying in cook-chill food (and sandwiches) rather than preparing any food on site.

High quality, mass produced cook chill 'ready meals' are of course popular when sold by Marks and Spencer, Waitrose and by other supermarkets.

Low budget

However the restricted budget for NHS meals (with amounts spent on food varying between trusts from as little as £2.12 per patient per day to £10.50 in 2015) limited the quality of ingredients, and the way they were actually served to patients, often luke-warm after being wheeled around a large hospital for an hour in a heated trolley, meant that they tasted very different from the dishes management were able to sample straight from the producer's oven.

And while an individual cook chill meal may appear to be cheaper than a freshly cooked one, they don't come as individual meals, but as trays of up to eight, which can mean high levels of waste.

With growing awareness of the hazards of single-use plastic and focus on environmental sustainability the large volumes of plastic packaging and additional food miles from production centres are an unnecessary environmental cost. When the Royal Free hospital reverted to home produced food it ended the need for 50,000 disposable plastic containers.

Martin worked with hospital staff to produce three excellent series of 'Operation Food', proving that investment into kitchens and locally sourced food could enhance the food for patients and for staff – reduce wastage rates and even generate a modest surplus where there had previously been a cost.

But it was an uphill battle against management who had decided in advance that cook chill, or the replacement of hot meals with sandwiches was the only way to go.

It was also done without any support from government.

When Health Secretary Jeremy Hunt in 2014 refused in advance even to consider bringing in new legislation to enforce minimum food standards in hospitals regardless of the outcome of an inquiry, one government advisor resigned in protest and Martin responded "You should be ashamed." He denounced the persistent refusal of ministers to take the issue seriously. "I've tried five years to speak to someone in government and the response is they're 'too busy'."

"I've tried five years to speak to someone in government and the response is they're 'too busy'."

Shutterstock

The report of the Hospital Food Standards Panel included a cost benefit analysis of some of the changes proposed, and estimated savings would more than cover the limited additional costs to a very modest annual spend of just over £500m a year on hospital meals for patients.

However the Panel argued against legislation to enforce action, and claimed it would be enough to introduce five recommended standards as "legally binding standards in the NHS Standard Contract".

Alex Jackson of Sustain, who resigned from the inquiry panel on this issue, pointed out that while school meal standards are enforced by law, there is no such legal safeguard for hospital food, and warned that what the Panel was proposing was "tinkering with commissioning contracts and hoping for the best".

He was right. In 2017 an article in Health Business noted that "negative discourse around hospital food dominates now, more than ever." It pointed to a review of progress two years after the HFSP's report which found widespread breaches of what were meant to be mandatory standards:

"For example, 48 per cent of hospitals were found to be non-compliant with the Government Buying Standards, whilst only 55 per cent of hospitals follow the BDA's Nutrition and Hydration Digest."

The food standards introduced into the NHS Standard Contract were not comprehensive enough, and because no real regulatory programme had been introduced, the result had been slow adoption of the standards.

Wrong issues

Perhaps even more worrying, the Panel had focused on issues which were not central to patients' concerns. In particular there were "no stipulations in the Government Buying Standards regarding the quality of food procured and served. In fact, this is not touched upon in any of the five standards introduced."

As a result the Panel missed the crucial point: "Even if meals and ingredients are ethically sourced, kind to the environment and nutritious, if they are badly presented and bad tasting, patients will ultimately be dissatisfied."

Part of the problem was obvious from the start: the Panel's 2014 report avoided any reference to the very low average amount available for catering managers to spend per head on NHS food – a point repeatedly stressed by the Hospital Caterers Association, which pointed out that when James Martin's first BBC 'Operation Hospital Food'

series was broadcast:

"It clearly highlighted the lack of investment in hospital kitchens and the limited food costs that many caterers are working with. James Martin was quoted as saying that the daily NHS budget allocation per patient was £3.49 for all food and beverages but in fact many caterers are having to work with far less.

"For many Trust Boards, catering is viewed as a low priority and in this period of economic crisis, many are looking for more ways to make cost savings".

The HCA also followed up after the third series in 2014, arguing that:

"We are aware that we still need to address a range of quality issues and establish uniform standards across the country.

"The HCA is, therefore, calling for a minimum food spend per patient per day as part of a campaign for the introduction of mandatory national nutritional standards for hospital food.

"We also want to stop CIPs (Cost Improvement Programmes) being applied to catering as short term solutions versus more effective long term funding".

Five years later, with both main political parties apparently calling for catering to be brought back in-house, but with real terms hospital budgets only fractionally higher than they were in 2010, it remains to be seen if we are really much closer to the necessary investment in kitchen facilities and staff that could make this a reality.

■ A future article will look at the alternative examples of how catering is done in Wales.

Campaign to bring NHS catering back in house

The Good Food Chain, the company that appeared to be at the heart of the listeria-contaminated sandwich scandal that caused the death of patients, has gone into liquidation. But the story does not end here. They were only a symptom of the dangers currently inherent in NHS food provision, argues PETE GILLARD, in a comment piece published by Keep Our NHS Public.

The Good Food Chain had been found by the Food Standards Agency ***not*** to be the source of the listeria. It seems it originated with their supplier of cooked chicken, Northern Country Quality Foods. The Good Food Chain were given the all clear to resume production.

But they faced a problem. They had to reapply for NHS accreditation. Given most of their business was with the NHS, the 43 NHS Trusts they supplied with cold meals, sandwiches and salads, they chose not to wait around for that to happen.

The Good Food Chain was a small company. It only employed 125 people, similar in numbers to a large hospital kitchen. It had no particular skill in preparing food for sick patients.

Cutting costs, cutting corners

The process of outsourcing food production from hospitals has been ongoing since the 1980s. Most of the new-build PFI hospitals were only provided with kitchens suitable for reheating pre-prepared meals, not cooking from scratch.

The drive has been to cut costs. Staff in private food production firms are frequently paid only the minimum wage. They do not receive NHS pay and conditions.

They are not part of the NHS family and cannot be expected to have the same loyalty, and understanding, of the NHS that directly employed staff do.

At the same time as staff costs are being cut, so is the overall cost of patient meals. Lord Carter's review of NHS spending in 2016 specifically targeted food costs. The average cost of a patient meal then was £2.70. Carter asked why some trusts were spending 2.6 times more per meal than the least expensive ones. NHS Improvement is calling for further cuts this year.

That is why sandwiches and salads have become so popular with hospital administrators. There is no reheating needed and it takes less time and effort prior to being served on the wards.

The regulator, the Food Standards Agency, has made this easier. In 2016 it relaxed its guidance that vulnerable patients should only be given sandwiches with a doctor's approval. Now all that is expected is 'good practice controls' to manage risk. All the patients who died in this listeria outbreak were vulnerable. If the Food Standards Agency had not changed the rules, they might not have been given the contaminated sandwiches.

As Nigel Hawkes in the BMJ points out that: "If hospitals provided hot food, infection by listeria would be prevented."

A risk to health

The cost-drive shift to cold food increases the risk of these sort of outbreaks. It is not as though outsourcing has led to better quality of food.

Research by the Campaign for Better Hospital Food in 2015 found that 1 in every 4 hospital meals was thrown away uneaten by the patients to whom they had been served.

A survey by Unison earlier this year of NHS employees saw 53% of the respondents saying that they would not eat food prepared for patients.

Patient food now seems to be seen as primarily as a cost factor. It is usually listed under 'Estates' in lists of savings to be made. There must be a recognition that good nutritious, and attractive, food is a key part of the care that should be provided in our hospitals. Outsourced suppliers, sandwiches, and unappealing reheated meals do not meet the need.

Even NHS England have recognised that nutrition training is now ignored in medical schools. Nurse training similarly rarely has more than a single lecture on nutrition in their training. And the professionals, the dieticians, as allied health professionals, are frequently in job roles that are amongst the first to be cut back when cost savings are made.

Further action is needed

If we want to avoid more tragedies like this listeria outbreak, we must reverse the current approach to food provision for patients. Keep Our NHS Public calls for patient nutrition to be considered centrally as a health issue not a cost issue.

We call for the ending of outsourcing of catering and the reinstatement of hospital kitchens, staffed by NHS employees, that can provide the hot meals and specialised diets needed by patients.

We call for NHS England to make good on their suggestion of the need to improve nutrition training for doctors, but also to extend it to nurse training, and to current staff who have received inadequate initial training.

Why are NHS hospitals and GP surgeries crumbling?

By Sylvia Davidson

The NHS's infrastructure is crumbling and disintegrating - 50% of GP surgeries are not fit for their current purpose, according to the BMA, and recent data shows that £6 billion is needed to complete the backlog of maintenance needed in hospitals and clinics.

Media reports have shown hospitals suffering sewage and water leaks, broken scanners and lifts, and inadequate heating.

Back in 2017, the Naylor report estimated that £10 billion would be needed to make the NHS fit for purpose and deliver the plans that had been drawn up around England to improve the NHS. The plan was for the NHS to raise at least £6 billion of this itself from land and property sales.

So what has happened since the Naylor report - well judging by the current situation, very little of the estimated £10 billion has materialised and what money is available has, has been spent on patching up and making do, rather than modernisation and making the NHS fit for purpose.

So who is responsible for the NHS infrastructure - its buildings and equipment?

The vast majority of the NHS infrastructure, hospitals and clinics, is owned by NHS trusts. Another chunk (12%) is leased from NHS Property Services Limited, a company wholly owned by the Secretary of State for Health and Social Care.

In primary care, the majority of GP surgeries are either owned by GP partners, primary care companies or leased from private landlords.

The upkeep and modernisation of the vast majority of these properties, in particular hospitals, is the responsibility of the NHS trusts. This is covered by the capital budget element of the NHS budget.

The upkeep and modernisation of privately owned GP surgeries is the responsibility of the GP partners or the primary care company that runs the surgery, or the private landlord that owns the surgery, depending on the leasehold agreement. GPs can apply for grants from NHS England to modernise their premises, otherwise they have to take out loans.

What is meant by the capital budget?

There are two types of NHS spending: capital and resource. The NHS's capital budget is used to fund long-term investments, such as buildings, equipment and IT, plus some maintenance and research and development. The resource budget is for the day-to-day running of the NHS, for staff and clinical services.

In recent years only around 60% of the NHS capital budget reaches NHS trusts, with the rest allocated centrally to areas such as research and development and other capital initiatives.

For each financial year, the NHS trusts, submit their plans for capital spending to the Department of Health and Social Care (DHSC). The sum total of these plans should not exceed the allotted budget for capital spending in the coming year.

Is there a budget for primary care infrastructure modernisation?

In December 2014 the government announced that £250 million per year (over four years) will be available to be invested in modern premises and technology. This was known as the "Estates and Technology Transformation Fund".

Some additional money has been allocated since, including £1 billion in June 2015, and in April 2016, NHS England set out an additional investment of £2.4 billion a year by 2020/21 into general practice, although this was not specifically for infrastructure modernisation.

The BMA survey, however, shows that this has not had sufficient impact on the sector. It appears that much of this money was targeted at creating seven day access to GP surgeries and increasing the workforce, rather than modernisation of GP surgery buildings.

The increase in capital funding was a pittance compared with the £6 billion worth of backlog maintenance that needs to be carried out by NHS trusts

What has happened to capital spending in recent years?

According to the Health Foundation the capital budget for hospital infrastructure has fallen in real terms over the last eight years, with NHS trusts in England seeing a 21% reduction in capital funding.

In 2010/11, capital spending by the DHSC was £5.8 billion, but by 2017/18 this had fallen in real terms to £5.3 billion, a fall of 7%.

As a result, the capital budget in 2017/18 was 4.2% of total NHS spending, compared with 5% in 2010/11.

Although these are the capital budget figures, it does not represent what has been spent over the past eight years. The constraints on the resource budget for day-to-day running of NHS clinical services and trying to keep waiting lists down, has meant that hospital trusts have raided their capital budgets, transferring money to enable clinical work to continue. As a result, work has not been carried out to maintain hospitals or upgrade facilities.

The capital budget for 2018/19 was £5.9 billion, which increased the overall to 4.6% of total NHS spending. This rise was a pittance, however, compared with the £6 billion worth of backlog maintenance that needs to be carried out by NHS trusts, according to NHS digital figures for the year 2017/18.

This backlog figure of £6 billion is the highest on record and over half of the backlog represents a "high" or "significant" risk to safety.

The NHS definition of its high-risk repairs are those that "must be addressed with urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution".

What effect is the lack of capital spending having on the NHS?

There have been regular reports in the media of hospitals suffering flooding, IT crashes and sewage system failures. These media reports are just the tip of the iceberg, however, there are many other incidents that don't make it to the media. Any incident interrupts day-to-day working, makes it harder and more stressful for staff to do their jobs, can worry and upset patients, and altogether reduces the efficiency of the NHS.

The BBC series Hospital opened its last series in January 2019 with scenes of a flood in the A&E department of the Royal Liverpool Hospital. Staff spoke of this being a regular occurence and their concerns of electrical failures and its effect on patient care.

A freedom of information request to all hospital trusts in England by The Labour Party, the results of which were reported in July 2019, found that in 2018/19 at least 76 hospital trusts in England recorded incidents caused by "estates and infrastructure failures".

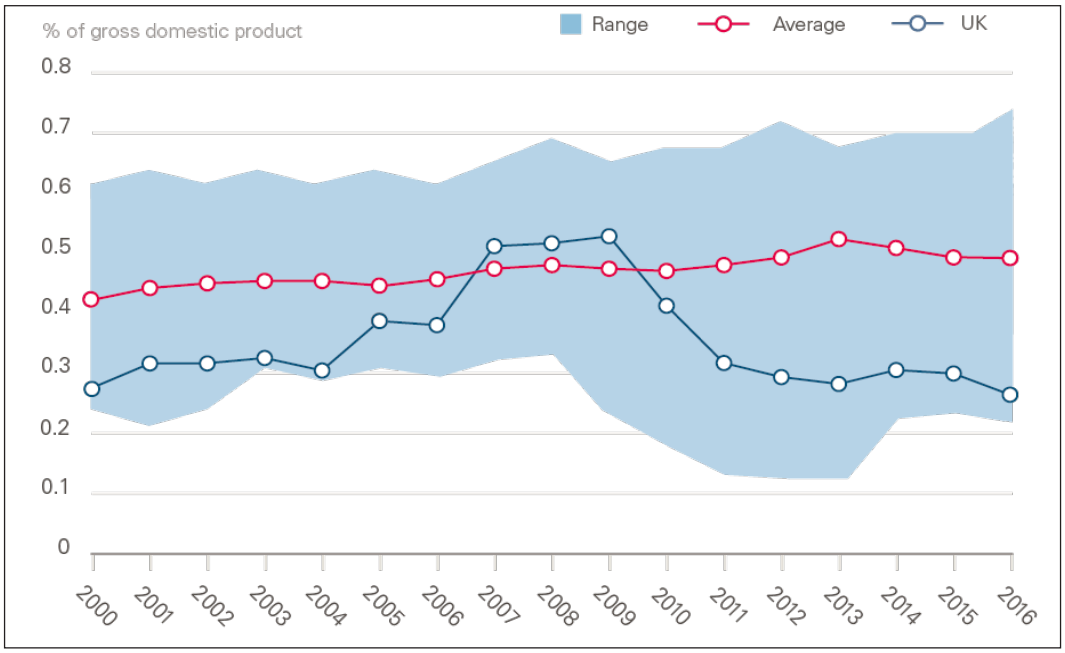
Replies were received from 170 hospital trusts cataloging a range of incidents. Many involved sewage, including sewage coming through the floor on the ultrasound corridor of one trust in Yorkshire and the Humber.

Other incidents included leaks of wastewater and water into hospital wards, sewage coming up through the bathroom drains, broken lifts, inadequate heating systems, water running down walls and broken scanners.

July 2019 saw fire chiefs threaten to close down parts of four hospitals as they were so rundown they had become a hazard to patients and staff. The hospital trusts must now make improvements or face legal action.

Collapsing infrastructure is not confined to hospital trusts. In February 2019 a survey by the BMA found that only half of GP practice buildings in England are fit for purpose.

July 2019 saw fire chiefs threaten to close down parts of four hospitals as they were so run down they had become a hazard to patients and staff.



Source: The Health Foundation, Organisation for Economic Co-operation and Development (OECD) data for OECD countries for which data for all years were available: Austria, Canada, Denmark, Finland, France, Greece, Ireland, Norway, Sweden, USA.

How do we compare to other countries?

Our spending on infrastructure does not compare favourably with other developed countries. According to the Health Foundation's report, Failing to Capitalise, to increase the NHS's capital funding in line with the OECD average, the budget would have to be £9.5 billion in 2019/20 - £3.5 billion on top of the current 2018/19 budget, and by 2023/24 an extra £4.1 billion would be needed.

Furthermore, this budget would all have to remain in the capital budget, with no transfers to day-to-day running of the NHS.

The survey also found around eight in ten practices said their practices were not suitable for future needs or anticipated population growth.

GP practices who lease their premises from the government-owned NHS Property Services also face the additional problem of rising rents and incorrect service charges. In June 2019, the BMA wrote to NHSPS asking it to address "astronomical" service fees for GP practices or face legal action.

The BMA notes that over the last three years, GP practices leasing their surgeries have seen fees rise without agreement and they have been charged for services that they are not getting.

So is capital spending going to increase?

The capital budget for 2019/20 will be higher than in 2018/19, with some suggestions that it could be £6.7 billion. This budget has yet to be set by the treasury.

However, with a backlog of £6 billion in maintenance at the end of 2017/18, it is clear that the budget will not be sufficient. Furthermore, it is still possible for trusts to siphon off money from this budget to fund day-to-day running of the NHS.

At the start of the 2019/20 financial year, the hospital trusts submitted their plans for capital spending over the coming year to the DHSC. Due to the backlog in maintenance, the trusts naturally planned for a considerable amount of work. As a result, the hospital trusts collectively submitted spending plans that exceed the capital spending limit imposed by the treasury, according to the DHSC.

In a leaked letter seen by HSJ, the DHSC sent an instruction to all trusts, asking them to cut their planned 2019/20 spending to bring it back in line with the central spending limit.

THE lowdown

Revelations fuel campaign against NHS charges and passport checks

Shocking revelations on the Victoria Derbyshire show have helped to drive a further strengthening of the campaign against legislation linked to Theresa May's "hostile environment" policy which requires NHS trusts to impose charges on patients without British passports, or who cannot prove they are normally resident in the UK.

Dr Joe Rylands told the BBC that he knew of a family who were denied access to the body of their baby because they were unable to pay the £10,000 bill. The family had been on holiday when the woman started bleeding severely and needed an emergency caesarean section. Sadly the baby died shortly after delivery.

The show also interviewed an Overseas Visitor Manager – the person who finds and charges patients – who revealed how they would simply scan hospital lists and pick out people with "foreign sounding names".

This bears out the suspicions of campaigners, who point out that a substantial minority of patients are being singled out for checks, apparently on arbitrary racial lines.

Earlier this year a Freedom of Information request by the Save Lewisham Hospital Campaign revealed that 18% of 9,000 women who gave birth in 2017/18 in the two hospitals in Lewisham and Greenwich were challenged to prove their entitlement to NHS treatment, and around a third of these, 541 women were charged.

Now the Royal College of Midwives has toughened its stance to demand the charges be suspended until it can be proved they are not harming women. The RCM also call for maternity care to be exempt from charges, whic "could put off women who need care but are frightened that they may not be able to pay in the longer term. This is potentially dangerous for the woman and her developing baby."

Protests have been held at hospitals in Bristol (above) Liverpool and London

The charges have also been opposed by the British Medical Association (BMA) and the Academy of Medical Royal Colleges.

The campaign against them is led by Docs not Cops, Medact and Patients not Passports, who are urging people to write to demand the Department of Health and Social Care commit to maintaining a truly universal NHS, available to all that need it, and specifically to stop charging for NHS care and repeal the 2015 and 2017 NHS Charging Regulations.

A Department of Health spokesman seeking to justify the charges claimed that since 2015, charges for people who are not UK residents had secured "an extra £1.3bn for front-line NHS services."

However this figure is deceptive. An investigation by FactCheck in 2017 pointed out that the initial target of raising £500m a year from charges did not just include the new upfront charges:

"Instead, it is the total annual amount that the government wants to recoup from treating overseas visitors by 2017/18. Upfront fees are only a very small part of this."

Fact Check found that most of the £500m was expected to come from other types of charges, such as pre-paid visa surcharges, which were introduced in 2015, and which are paid mainly by students and longer-term migrants from outside the European Economic Area.

The NHS had already become far better at identifying these debts before upfront fees were introduced and collected £358m in 2016/17 – which seems to correspond with the claimed £1.3 billion raised over 4 years.

Help us make this information available to all

We really want to run this publication without clumsy paywalls that would exclude many activists – but if we are to develop new expertise we do need to recruit staff, and so we need the resources to pay them.

We are therefore planning to fund the publication through **donations from supporting organisations and individuals** – and we are very grateful for those individuals and organisations who have already given or promised generous donations to enable us to start the project going.

Our business plan for the longer term includes promotion of *The Lowdown* on social media and through partner organisations, and to develop a longer-term network of supporters who pay smaller amounts each month or each year to sustain the publication as a resource.

But we still need funding up front to get under way and recruit additional journalists, so right now we are asking those who can to as much as you can afford to help us ensure we can launch it strongly and develop a wider base of support to keep it going.

We would suggest £5 per month/£50 per year for individuals, and at least £10 per month/£100 per year for organisations.

Supporters will be able to choose how, and how often to receive information, and are welcome to share it.

On the website we will gratefully acknowledge all of the founding donations that enable us to get this project off the ground.

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

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