The lowdown

Health news and analysis to inform and empower NHS staff and campaigners

NHS England takes control – but hides key virus and bed stats

NHS England (NHSE) boss Sir Simon Stevens has been wheeled in to help justify the belated government lockdown to stem the rising tide of covid-19 infection, pointing to the dramatic escalation of numbers hospitalised with the virus to 11,000 ("equivalent to 22 hospitals full of covid-19 patients").

Something had to be done. Johnson's 'three tier' approach of local lockdowns, coupled with the shambolic failure of the privatised 'test and trace' system was losing control as the virus was spreading from the North West and Yorkshire.

However NHSE has also seized the opportunity to take back centralised control over England's NHS. This eliminates any vestiges of local accountability, but also brings a further extension of the information blackout that has fuelled the cranky right-wing politicians and columnists who oppose the lockdown.

For example, one so-called "Science Editor", quoting "a leaked document", claimed on 3 November: "Hospital intensive care is no busier than normal for most trusts... covid-19 patients are accounting for around 10 per cent of general and acute beds in hospitals, but there are still more than 13,000 beds available."

The argument is cynical and misleading. It manages not only to dismiss the mounting death toll (2000 have died in the past week, equivalent to ten major air crashes) – and ignore the crisis in those hospitals that are dealing with higher numbers of covid-19 patients than the first peak in the spring – but it also implies that all 13,000 beds theoretically available across England are accessible from anywhere – as if patients from Yorkshire could be treated in Surrey.

Covid-19 outbreaks have been geographically concentrated, and don't properly show up in national aggregate data. The problem is that as long as the full figures – compiled daily by NHSE but kept tightly under wraps – are concealed, it is much harder to reveal the scale of the problem across the NHS.

The HSJ on 2 November also quoted from (the same) leaked figures to point out, "There are 70 per cent more people in hospital now than when England was approaching its spring covid-19 peak, and twice as many non-covid patients." The Independent on 3 November also quoted leaked figures showing covid-19 admissions had increased 60 per cent in just ten days.

NHS Providers chief executive Chris Hopson on Twitter also argues actual NHS acute bed capacity has been reduced by 10-30 per cent by the need to separate covid-19 from non-covid patients. There are 80,000 NHS staff vacancies and higher rates of sickness absence.

Hopson warns of the "clear risk of a perfect storm" involving a full-blown second wave, and the usual winter pressures, as well as work to reduce backlogs in elective treatment. Daily admissions of covid-19 patients are higher than on 23 March when the first lockdown was imposed.

The Nightingale hospitals, supposedly offering extra capacity, could only be used by diverting large numbers of vital staff from already over-stretched NHS hospitals.

Even prior to covid-19 an NHS starved of resources by ten years of effectively frozen real-terms funding was struggling to cope with each winter. In the spring the NHS only 'coped' by emptying up to 30,000 beds and cancelling outpatient and elective work, while A&E caseload fell as even patients with serious illness were scared off by fears of catching the virus.

Now, after the government ignored the calls from its own scientific advisers for a pre-emptive two-week 'circuit breaker' lockdown across the half-term holidays, ministers have at last recognised that an NHS with fewer beds, exhausted staff, care homes still locked in crisis, looming winter and the virus untracked and out of control, would not cope without a lockdown.

The case for it is clear: the argument for it would be so much easier with full and open disclosure of the facts.

John Lister

Also in this issue...

US presidential election: on healthcare, neither party offered what voters wanted

Whether Trump clings on or Biden wins the US election – after the prolonged agony of one of the world's least efficient and least democratic electoral systems, and the seemingly inevitable involvement of courts and lawyers – the incoming president will face a mountain of problems over healthcare.

The issue is of immediate concern to millions of Americans, 72 per cent of whom, according to a poll published by – of all people – Fox News, "strongly" or "somewhat" favour the option of changing to "a government-run health care plan".

This of course is close to the 'Medicare for All' policy popularised by Biden's main challenger for the Democratic nomination, Bernie Sanders, but rejected by both Trump and Biden, along with many of the more conservative layers of Democrats. Medicare is a publicly-funded healthcare plan for seniors, and would create a "single-payer, national health insurance program to provide everyone in America with comprehensive health care coverage, free at the point of service", with "No networks, no premiums, no deductibles, no co-pays, no surprise bills."

Prohibitive costs

The issue of healthcare has come to the fore in the US, with the covid-19 pandemic, which was far and away the biggest concern of voters in the Fox News poll. Almost 27m Americans lost their employer-based insurance in the first two months of the pandemic, and now face the grim prospect of paying through the nose for personal or family insurance policies, or the risk of financially crippling medical bills if they require any treatment.

But the commercial provision of healthcare also means that the costs are prohibitive. Insurance costs are inflated by hospitals charging private insurers an average of 240 per cent of the fees they charge the publicly-funded Medicare system for the same care, according to a recent survey. If private health plans paid hospitals using Medicare's payment rates, the total payments to hospitals would have been reduced by $19.7bn from 2016 to 2018.

US hospitals run as businesses have been closing down, or putting staff on furlough during the peak of the pandemic – because there was no profit to be made from treating covid-19 patients – while hospital chains owned by three already profitable private equity firms picked up a staggering $2.5bn in cheap government loans and handouts designed to help struggling businesses get through the pandemic crisis.

Obama legacy

The most significant Democratic Party effort to address the problems of the ruinously expensive and unequal US healthcare system was President Obama's half-baked Affordable Care Act (ACA), negotiated with the insurance industry, which imposed an unpopular "individual mandate" requiring Americans not covered by workplace insurance to buy an individual policy, or face a penalty.

The ACA led to the creation of a whole slew of low-value, relatively low-priced "Bronze" insurance policies, which carried hefty deductibles (the excess level, up to which no payout would be made) and co-payments (the share of any remaining bill to be paid by the beneficiary), leaving many effectively uninsured except for the most catastrophic health bills.

This has been compounded by Trump's sponsoring of even lower-cost and less useful policies which would not meet the standards of the ACA: "My administration increased the availability of renewable short-term, limited-duration healthcare plans, providing options that are up to 60 per cent cheaper than the least expensive alternatives under the Patient Protection and ACA, and are projected to cover 500,000 individuals who would otherwise be uninsured."

Trump has boasted of having 'terminated' the individual mandate, although Congress has only removed the penalty for not taking out insurance, not scrapped the mandate. Republican state attorney generals are due to argue in the conservative-led Supreme Court for the ACA to be overturned on 10 November.

No alternative?

However Trump has become aware of the popularity of one key aspect of the ACA – the prevention of insurance companies from barring subscribers or charging them extra on the basis of pre-existing health conditions. In September he signed an executive order which declares: "It has been and

will continue to be the policy of the United States… to ensure that Americans with pre-existing conditions can obtain the insurance of their choice at affordable rates."

But as Kaiser Health News notes, "There is nothing in the order – or in the broader outline – to ensure that would be the case if the ACA were struck down." In other words Trump has committed to scrap the legislation that underpins one of his key pledges – but has made no clear proposals for any alternative legislation. This would pose immediate and serious problems to at least 135m Americans with pre-existing conditions, plus a significant number of the 3.9m adults aged under 59 who have contracted covid-19 and may have ongoing health problems.

Despite repeated promises to repeal the ACA in his first 100 days, and that a new plan was just about to surface, the Republicans have legislated only the 2017 American Health Care Act (AHCA), which kept in place some of the more popular provisions of the ACA, and which some Republicans refused to support, dismissing it as "Obamacare-lite".

Vacuous rhetoric

In June last year Trump said in an interview with ABC News "We're going to produce phenomenal healthcare. And we already have the concept of the plan. And it'll be much better healthcare." Similar claims have been repeated several times in 2020, but never followed up by a plan.

In September came Trump's executive order, replete with typically vacuous Trumpish rhetoric: "My administration has taken monumental steps to improve the efficiency and quality of healthcare in the United States."

But Kaiser Health News points out that few Republicans actually want a Trump plan to revamp healthcare: "Not having a replacement plan for the ACA may be just fine with many of his supporters and conservatives. Most Republicans don't want the federal government to remake the nation's health system, said Grace-Marie Turner, of the conservative Galen Institute."

Biden too is unlikely to make the bold moves on healthcare that even the Fox News poll shows the large majority of Americans are crying out for. The Democrats are deeply divided on these questions, with many politicians caught up with the powerful lobbying power of the "medical industrial complex" that defeated Bill Clinton's efforts at health reforms, and led to the dilution and effective neutering of Obama's proposals.

Even if he himself favoured it, it's also clear that Biden will not have control of the Senate, which is essential to be able to push through any radical change.

A poll for Kaiser Health News found that most voters preferred Biden's limited policies on health to Trump's. But having rejected the bolder proposals of Medicare for All, he has limited his offer to capping price increases for already overpriced brand name, and some generic, drugs, and giving consumers subsidies and tax credits to help pay exorbitant premiums, with an option to purchase a public insurance plan (which would be free for the poorest, based on need).

In June the Democrats in Congress passed a proposal to cap insurance costs at no more than 8.5 per cent of income, but were not able to agree on much else of substance, leaving Biden and party candidates mouthing promises not far different from Trump, pledging to "strengthen and improve our health care system to make it cheaper and easier for everyday Americans to get the care and coverage they need".

John Lister

The covid-19 pandemic triggered a "precipitous" drop up to 50 per cent in hospital admissions of non-covid-19 medical patients in the US, according to a study of almost a million medical admissions published in Health Affairs.

While some of this fall resulted from hospitals postponing or delaying elective surgery and non-critical medical services, there were also "puzzling" **declines in admissions** for serious conditions that require hospital care – such as pneumonia (down by 44 per cent), chronic obstructive pulmonary disease/asthma (by 40 per cent) sepsis (by 25 per cent), stroke and heart attacks. Similar studies indicate outpatient appointments and surgical admissions were also sharply reduced.

Non-covid-19 admissions were most reduced in patients from majority Hispanic neighbourhoods and higher for patients from majority Black neighbourhoods.

The authors suggest the explanation may be that many patients with acute medical illness were more afraid of contracting covid-19, or concerned that they might not be able to get in to hospitals swamped with covid-19 patients.

They warn that, in addition to the "implications for hospital solvency", falling hospitalisation of people who need it "could portend substantial harm to public health if patients defer care for life-threatening conditions". They suggest health system leaders and public health authorities need to focus on "how best to ensure that patients with conditions that require hospital care obtain it during the pandemic".

Covid-19 vaccines: when can they be used, and what's on the way?

THE ANNOUNCEMENT of a 90 per cent-effective vaccine by Pfizer and the German company BioNTech has raised the prospect that beyond the second wave of covid-19 infections a solution to a return to normal life is on the horizon .

According to the World Health Organization (WHO) there are more than 300 vaccine candidates in development, with around 40 in human clinical trials. Ten of these have reached the final stage – phase 3 – needed before approval for use in the general population.

The WHO and the US organisation that approves vaccines, the FDA, have determined that the minimum criteria for approval of any Covid-19 vaccine is a 50 per cent level of efficacy.

Although 50 per cent efficacy means that 50 out of a 100 people given the vaccine will get the disease – which doesn't sound that good – it is hoped that those that do get the disease will get a milder form, meaning fewer people in intensive care units and fewer deaths. This is the situation with the current influenza vaccines: some people do get flu, but with a milder form.

Each current phase 3 trial involves one group given the vaccine (in most cases in two doses) and another (control) group given a placebo. None of the participants know which they've received – this is known as a 'blind trial'.

Event-based

All of the current phase 3 trials are what are known as 'event-based'. This means that the trial ends (the endpoint) and the data is analysed when a certain number of people across both the vaccinated group and the placebo group have contracted the virus and shown symptoms.

This 'event-based' endpoint is used because although the perfect endpoint is complete prevention of infection, this has never been achieved for other coronavirus or influenza strains. Professor Andrew Pollard, who is leading phase 3 trials of the AstraZeneca vaccine, has noted that the major thing that is needed from a vaccine is to stop people being admitted to hospital, going into intensive care and dying.

UK investment

The UK government, via its vaccine taskforce, has heavily invested in a vaccine portfolio and has pre-ordered doses across six leading candidates. The taskforce has options to purchase sufficient doses of each type to vaccinate the appropriate UK population. This country is reported to be one of the highest investors in vaccine development, along with the US, Canada, Japan and the EU.

As the vaccine trials need to enroll thousands of people, the UK government has also launched covid-19 vaccine registry, which by October had enrolled more than 295,000 volunteers.

Of the six vaccines that the UK has options for, three are currently in phase 3 trials:

BNT 162b2

This vaccine is the leading vaccine, having almost completed a phase 3 trial that has enrolled over 42,000 participants across several countries. Initial results were reported in early November.

This vaccine is being developed by Pfizer and the German company BioNTech, in a phase 3 trial that has enrolled more than 42,000 participants across a number of countries. On 9 November the two companies reported the first data from the phase 3 trials, which found the vaccine to be 90 per cent effective, a far better result than experts had hoped for. effective, a far better result than experts had hoped for. The companies also reported that there had been no serious side effects. Now the trial will continue until there have been 164 confirmed cases,

which means that there may be a reduction in efficacy in the final analysis.

When the final safety data is collected, which will take until the third week of November, according to Pfizer, the data will then be submitted to regulators for approval. There is a possibility with fast-track approval that doses of the vaccine could be given before the end of the year.

However, it has been noted that release of results in this way via press release, rather by than peer-reviewed journal, is not usual. The BMJ reported that although experts have welcomed the news, they also emphasise how important it is to see the full results, which will include details such as the participants' demographic details, including age and ethnic group, and the severity of the cases reported in the trial.

Furthermore, the 90 per cent efficacy reported is an estimate of short-term efficacy based on seven days of follow-up of participants after they were given the second dose. There is as yet no data on long-term efficacy. Trial participants will be monitored for two years from the second dose to give data on safety and long-term efficacy.

Pfizer is producing the vaccine at a plant in Belgium and should have 100m doses of the vaccine for delivery by the end of this year. The UK has pre-ordered 40m of those doses. As two doses of the vaccine are required to stimulate an immune response against the coronavirus, that would be enough to vaccinate 20m people.

There was widespread positive media coverage of the reporting of the initial results, with many trumpeting a vaccine by year end. However, health secretary, Matt Hancock, speaking at a press conference, was more cautious, stressing that "we are not there yet". He also noted that full safety results are not out yet, and if these weren't good then the vaccine would not be rolled-out in the UK.

The roll-out of the vaccine will be a major undertaking – it needs to be given in two doses and to be stored at -70C until the last few hours before administration. The storage temperature is unusual in a vaccine and may cause some logistical problems.

Hancock states that he has asked the NHS, supported by the armed forces, to be ready for a roll-out at the start of December. The first populations to receive it will be people in care homes, elderly people and social care staff.

AZD 1222

This is one of the most advanced vaccines worldwide, and the most advanced vaccine that the UK has an option on, and it is nearing the end of phase 3 trials. It was originally developed by Oxford University and its spin-off company Vaccitech, but is now being developed with the pharmaceutical company AstraZeneca. In July, Oxford University researchers published the results of an initial clinical trial, which showed that the vaccine induced strong immune reactions in the participants.

One hiccup came in October when the phase 3 trial was put on hold due to a participant developing adverse effects, but it was very soon restarted.

This is the vaccine that the UK government appears to be pinning its hopes on for a rollout in late 2020/early 2021. In early November, Simon Stevens, head of NHS England, said the NHS was preparing in case a vaccine was available before Christmas, with the first to be vaccinated being the over-85s and frontline health workers.

However, Professor Andrew Pollard, head of the Oxford University group leading development, played down the chances of vaccinating people before Christmas in his evidence to a joint hearing of the parliamentary science and health committees. He said, "I think there is a small chance of that being possible, but I just don't know." The level of efficacy is unknown at the moment as the results have not been unblinded and the data assessed. However, Pollard was optimistic that this point will be reached before the end of this year.

NVX-CoV2373

This vaccine, developed by Novavax, began phase 3 trials in the UK in September. Many of the participants will be taken from the NHS covid-19 vaccine registry. Novavax will enroll 10,000 participants between the ages of 18 and 84 in the trial. Each trial participant will receive two doses.

Other vaccines

The UK has options on three other vaccines in development with Janssen, GlaxoSmithKline, andSanofi and Valneva. Kate Bingham, head of the UK vaccine taskforce, noted in an article in The Lancet that numerous phase 3 studies are planned to begin in the UK in 2020/21.

At roughly the same stage of development as Pfizer/BioNTech's product is Moderna's vaccine. Although still in phase 3 trials, this company has begun what is known as a rolling review of the data with the UK's regulatory authority, the MHRA.

The MHRA can launch an independent assessment of the vaccine using the information submitted by Moderna, and also accept new evidence as and when it becomes available, until the application is complete.

This approach speeds up the final approval process for the vaccine. The UK government, however, does not have an option on this particular vaccine.

Sylvia Davidson

NZ vote highlights failure to reform assisted dying law in UK

The outcome of last month's referendum in New Zealand, which gave the green light to the introduction of assisted dying, has yet to re-ignite the debate on this sensitive issue in the UK. Doctors' groups here continue to maintain a neutral or negative stance – seemingly at odds with the opinion of both the general public and their own members – and there is no legislation currently scheduled for parliamentary debate, either in the Commons or the Lords.

As we note below, other countries have managed to allocate parliamentary and judicial resources this year for similar legislation, despite the hurdles presented by covid-19, so why hasn't the UK government been more proactive? The public support for such a move is all too apparent.

A poll conducted in 2015 by campaign group Dignity in Dying (DiD) found that 82 per cent of respondents wanted to see assisted dying made legal – and 53 per cent would think more positively about an MP who supported it. DiD's follow-up survey saw similar levels of support, and noted there was even stronger support among people who stated they had a disability. It also found broad support for assisted dying across most faith groups.

Popular support

More recently, in 2019, another campaign organisation – My Death, My Decision (MDMD) – commissioned a survey from the National Centre for Social Research (NCSR) that discovered that more than 90 per cent of people considered assisted dying acceptable in some situations.

A previous NCSR survey, two years earlier, revealed that public support for euthanasia remained consistent with previous surveys dating back 30 years, with 78 per cent saying the law should definitely or probably allow a doctor to end the life of someone with an incurable and painful terminal illness.

The medical profession, however, has long adopted a more conservative approach to assisted dying than the general public. The British Medical Association's (BMA) current position – dating back to the 1950s – is that physician-assisted suicide, voluntary euthanasia and non-voluntary euthanasia should all remain illegal in the UK, and it assumes that "ongoing improvement in palliative care" already allows patients to die with dignity.

Compare this to the Netherlands, where one survey showed that in 2015 more than 90 per cent of GPs and 87 per cent of elderly care physicians supported the liberal Dutch approach to euthanasia and assisted suicide, possibly because the development of the associated legislation was carried out with input from the medical profession.

Nevertheless, the BMA is to debate its current stance at its AGM next June, specifically to consider the results of a survey – its first-ever on assisted dying – which last month found that 40 per cent of the 29,000 members who responded think the organisation should actively support a change in the law, and just 33 per cent want it to retain its opposition to such a move. Around 20 per cent of respondents think it should revisit its 2005 stance of neutrality.

MPs not MDs to decide?

Similarly, the Royal College of General Practitioners (RCGP) is maintaining its 14-year opposition to assisted dying, despite a majority of GPs (51 per cent) voting earlier this year either to support a change in the law or to adopt a neutral stance – a major change since 2013 when 77 per cent of members polled were opposed to a change in the law.

Meanwhile, the Royal College of Physicians (RCP) reaffirmed its position of neutrality in March this year, although an online survey of its members 12 months previously showed more respondents were either neutral or supported a change in the law than were opposed to it, largely mirroring the RCGP survey results.

But with the RCP acknowledging that "the ultimate decision on assisted dying rests with society through parliament", it seems that MPs bear most responsibility for the lack of progress towards the adoption of assisted dying in the UK.

Many attempts at legislative reform (all unsuccessful) have been made here, from 1931 – when the president of the Society of Medical Officers of Health proposed a voluntary euthanasia bill for incurable invalids – right up to the present day, when the latest iteration of Labour peer Lord Falconer's Assisted Dying Bill stalled in the House of Lords earlier this year.

It remains to be seen whether a suggestion in August from Tory MP Andrew Mitchell, co-chair of an all-party parliamentary group on the issue, that assisted dying would become legal within the term of the current parliament is any more successful.

Other countries – Belgium, Canada, Colombia, Luxembourg and the Netherlands – have already passed laws that permit eu-

thanasia, and assisted suicide has been allowed in Switzerland since 1942. Assisted dying is legal in several states in the US (including California, Hawaii, Oregon and Washington State).

And this year has seen further moves internationally towards introducing or liberalising assisted dying legislation.

Seven months ago a parliamentary committee recommended that the Australian state of Queensland should legalise voluntary assisted dying for adults with an advanced terminal illness. MDMD notes that currently more than one-third of Australians have, (or shortly will have), access to a form of assisted dying since the state of Victoria passed its voluntary assisted dying law in 2017, followed by Western Australia in 2019. If Queensland follows, this would give the option of an assisted death to well over half (57 per cent) of Australians.

International perspective

In Canada, legislation known as Bill C7 and provisionally approved last month is set to liberalise access to euthanasia and assisted suicide, although this particular move led UK campaigning group Care Not Killing to highlight one aspect of assisted dying that is rarely publicised – a government estimate predicted that the new law would save £87m in healthcare expenditure in the first year alone.

Germany repealed a ban on assisted suicide services in February. The country's constitutional court ruled that to deny adults the right to professional assistance unlawfully denied them a 'right to a self-determined death'.

In Ireland, at the beginning of October, TDs in the Dáil voted to progress a Dying with Dignity Bill to committee stage, bringing the option of assisted dying for terminally ill Irish citizens a step closer to becoming legal.

A few weeks ago the Dutch government approved plans to allow euthanasia for terminally ill children aged between one and 12 (it was already legal for children older than 12 in that country, with mandatory consent from the patient and their parents).

And in Scotland last month the Scottish National Party was said to be considering assisted dying proposals to be debated in Holyrood next May, an idea supported by 76 per cent of respondents in a subsequent survey conducted by DiD.

But it's back to New Zealand that we should look, to see how ethical considerations determined the latest adoption of assisted dying. The legislation that formed the basis of the referendum there – the End of Life Choice Act, passed by the NZ parliament in 2019 – succeeded in addressing these considerations simply by introducing a set of criteria that a person has to meet before they're allowed to proceed.

That person must be: suffering from a terminal illness that's likely to end their life within six months, showing a significant decline in physical capability, and able to make an informed decision. The criteria do not include advanced age, mental illness and disability alone.

Lack of space in The Lowdown precludes further exploration of the various pro- and anti- arguments put forward whenever assisted dying legislation is proposed, but readers who'd like to know more may want to check these links: BMA, Care Not Killing, DiD, Disability Rights UK and MDMD.

Martin Shelley

Win-win situation for private hospitals

AN EXULTANT article featuring the grinning director of the Independent Healthcare Provider Network (IHPN), David Furness, in the October issue of Healthcare Markets magazine reminds readers that the dire situation of the NHS has opened lucrative doors for the 'independent' sector.

With a 'best case' scenario of NHS waiting lists doubling from the "already record high of four million", Furness argues, NHS England (NHSE) has set up a framework contract to buy in around £10bn of additional capacity from non-NHS providers over the next four years.

"Such a substantial contract with the independent sector would ordinarily have stimulated much debate on the merits of NHS/private partnerships," Furness continues breathlessly. "But in this current climate it almost passed under the radar, with even the most ardent critics of the sector struggling to convincingly make the case that the NHS should not be sourcing all available resources in order to improve patient access to care."

Saving the private sector

This of course raises a number of questions: exactly what resources does the private hospital sector really have to offer, at what financial and organisational cost?

Despite the IHPN's bravado it becomes even clearer on close analysis that the huge injection of NHS and public sector funds has been more of a life-saver for the private hospitals than it has for the NHS.

NHS hospital trusts have been struggling financially, having received almost none of the £32bn extra government funding for health-related services to tackle the covid-19 pandemic.

Trusts' financial situation has got worse recently, with grim warnings of the increased demand on NHS beds and intensive care units from the second wave of covid-19 patients combining with the usual increased 'winter pressures', and a funding gap conservatively estimated at £1bn, while they also face financial penalties for failing to deliver hugely ambitious NHSE targets to resume previous levels of routine elective and emergency services.

By contrast the initial big, lucrative deal with NHSE in March to 'block-book' up to 8,000 private acute sector beds through to the end of May, at a total cost of almost £1.6bn, guaranteed the private sector "cost recovery for its services, including operating costs, overheads, use of assets, rent and interest, less a deduction for any private elective care provided".

Financial cushion1

The private hospitals, and their lenders and landlords, were cushioned against the impact of covid-19 on their core business. The published contract reveals that £1.57bn was shared unequally between 26 private hospital corporations, each of which picked up payments ranging from £0.9m to £346.6m to Britain's largest private hospital group, which is now Circle Health Holdings, having completed the takeover of the previous market leader, BMI Healthcare, in August.

The other big winners were Spire Healthcare Ltd (£345.9m), Australian-owned Ramsey Health Care (£271.1m), Nuffield Health (£165.2m), US-owned HCA International Ltd (153.2m) and Care UK (£76.3m). The remaining £218m was carved up between 20 smaller companies.

But while the initial focus was on private hospital beds being used, online news site HSJ points out that in many cases the initial contracts "paid for staff and equipment to be transferred to NHS hospitals, as opposed to paying for ward space in private hospitals". The press office of Spire Hospitals confirms this analysis.

Most private hospitals are of limited use to the NHS, since they tend to be small in scale (averaging just 43 beds) and geographically separate from the main NHS acute centres, and because the private hospitals are primarily staffed with nurses, with relatively few doctors, most of whom work in them on a part-time sessional basis while employed by the NHS. Making more use of private hospitals therefore means diverting more NHS staff to do the work, and separating them from the main clinical workforce.

Hidden numbers

The NHS made no significant use of private hospitals for covid-19 patients, and a limited number of specific publicised examples underlines the fact that there was also limited use of private hospitals to treat NHS elective patients. So how many of the potential 8,000 block-booked beds have been used by the NHS? It's hard to tell from the limited information published by NHSE.

What we can tell from recent articles in Healthcare Markets is that private hospitals have begun to use many of the beds the NHS has opted not to use, to cash in on increasing numbers

of self-pay and privately-insured customers seeking to jump past lengthening NHS waiting lists.

In mid-June the Guardian reported a sceptical Treasury blocking plans for a £5bn extended contract to use private hospitals into 2021, because of concerns over how many of the beds were being used. It that "NHSE has refused to disclose how many patients have been treated by private providers since March, even though they collect this data each day."

In mid-August Spire announced that a variation of the initial NHS block-booking contract was going to give the private hospitals more scope to increase their own private patient caseload:

"The NHSE contract, and subsequent variation, is expected to remain in place until at least the end of October but will have a definitive expiry date at the end of December. The most significant variation is to guarantee that a certain minimum capacity in each hospital will be made available for privately funded patients (PMI and self-pay).

"Private activity has been building steadily since the de-escalation phase of the NHSE contract was triggered on 15 May."

Drinks all round

At almost the same time the Independent broke the story that a massive new 'framework contract' was being offered, which makes it easier for private hospitals to be contracted to take on NHS waiting list patients: "The health service could spend up to £10bn of taxpayers' money buying operations and treatment in the private sector over the next four years to reduce waiting times."

However, questions remain unanswered on how many private beds are still being booked – and used – by the NHS at local and national level, and at what cost. September statistics from NHSE revealed that only 2,300 of the undisclosed total of private acute hospital beds block-booked by NHSE were being used in early September.

According to the latest issue of Healthcare Markets the private sector is benefiting two-fold: not only are the private hospital firms celebrating "strengthened ties" with the NHS and the prospect of sharing £10bn revenue from waiting list contracts over the next four years, but conventional private hospital activity is also recovering to pre-pandemic levels, with private cancer treatment exceeding 2019 levels.

With NHS acute bed numbers in England down from 109,000 in 2010 to less than 100,000, and a soaring NHS waiting list with operations being cancelled this winter, it's good news all round for the private hospitals, who win out whether patients go private or stay in the NHS queue.

John Lister

**This article is abridged and adapted from John Lister's new book 'Pandemic: Where are we still going wrong?' to be published this month by Bite Sized Books.*

GPs suffering abuse over mistaken belief that surgeries are closed

MORE THAN a third of doctors have suffered verbal or physical abuse from patients or their relatives during the past few months of the covid-19 pandemic, according to a recent survey of GPs by the medical indemnity organisation the Medical Protection Society (MPS).

The reported abuse includes graffiti and notes through the door, and has not been confined to surgery premises, with GPs receiving abuse while out in supermarkets and elsewhere.

The survey of 1,250 doctors, from mid-September to mid-October, found that 35 per cent of respondents had faced verbal or physical abuse, and 7 per cent had experienced abuses while outside of work.

Much of the abuse relates to the mistaken belief that GP surgeries are closed and doctors are not seeing patients face-to-face. Graffiti at one doctors' surgery in Bristol in late October implied the GPs didn't care and a note through a GP surgery door in Suffolk implied that the GPs were not available.

At the start of the pandemic the message from the government of 'Stay at Home, Save the NHS' resulted in a huge drop in people seeking help from GP surgeries.

Face to face

GPs were given guidance to triage patients, and health secretary Matt Hancock and NHS England (NHSE) pushed the widespread move to digital access via telephone and Skype appointments. Surgeries responded accordingly and rapidly changed the way they worked, but at no time did they stop face-to-face appointments entirely or close.

The guidance and government messages led to a sharp downturn in GP visits, but the most recent data on GP consultations by NHS Digital shows that the figures are back up again.

Indeed, the figures are up substantially, with higher demand than at the same time in 2019. In September there were a million more GP appointments than September 2019, 1.5m more same-day appointments than the same period last year, and 56.6 per cent of appointments were face-to-face.

So why the mistaken belief that GP surgeries are not doing face-to-face appointments or are closed? Well much of the recent abuse targeted at GPs has been blamed on a letter sent by NHSE in September.

The letter to GPs was to remind practices of their duty to provide face-to-face appointments, and warned that the failure to do so could constitute a breach of contract. A press release to national media on the subject sparked a deluge of negative coverage about a lack of GP access. The BMA demanded NHSE issue a correction, and said, "Any inference that in-person consultations were put on hold is an affront to the committed GPs who have continued to go to work throughout the pandemic."

NHSE's primary care medical director, Dr Nikita Kanani, has since apologised for the letter.

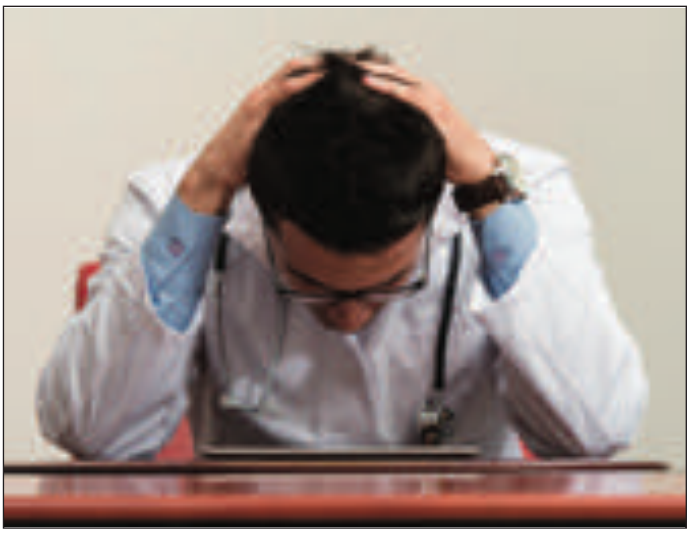
Problem guidance

Comments in the MPS survey also noted the guidance the GP surgeries are following for triage – NHSE guidance that all patients should be remotely triaged while the pandemic continues – is also a major source of complaint and a trigger for abuse.

The increase in abuse comes at a time when two out of five doctors said their mental wellbeing is worse compared to the start of the pandemic.

The British Medical Association's GP committee chair Richard Vautrey wrote to NHSE and NHS Improvement executive director Ian Dodge at the end of October, calling for GPs to be given urgent support. Commenting on the latest consultation figures, he said: "Today's figures show that GP practices are very much open for business."

However, GPs face a very difficult winter ahead, with demand up, new complex working arrangements and longer hours.



To help secure the future of our NHS through campaigning journalism, please support us

Dear Reader

Thank you for your support, we really appreciate it at such a difficult time. Before covid-19 the NHS was already under huge pressure, and after it's all over there will be a backlog of patients, queues of people affected by the crisis, and a hugely tired workforce.

From that moment we will need a much more credible plan to fund, support and protect our brilliant NHS. Our goal is to help make this happen and we need your help. We are researchers, journalists and campaigners and we launched The Lowdown to investigate policy decisions, challenge politicians and alert the public to what's happening to their NHS.

It is clear from the failures of recent years that we can't always rely on our leaders to take the right action or to be honest with us, so it is crucial to get to the truth and to get the public involved. If you can, please help us to investigate, publicise and campaign around the crucial issues that will decide the future of our NHS, by making a donation today. Our supporters have already helped us to research and expose:

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

First we must escape the covid-19 crisis and help our incredible NHS staff. We are helping by reporting the facts around the lack of protective equipment for hospital staff but also for thousands of carers. We are publishing evidence about more community testing and the shortcomings in our strategy to beat the virus. Even though they have a tough job, there have been crucial failings: on testing, PPE and strategy, and we must hold our politicians to account and challenge them to do better. We rely on your support to carry out our investigations and get to the evidence.

If you can, please make a regular donation, just a few pounds a month will help us keep working on behalf of the public and NHS staff - thank you. We all feel such huge gratitude and respect for the commitment of NHS staff and it's so impressive to see such strong public support. Let's hope that we can give the NHS the thanks it deserves and crucially, secure its future.

With thanks and best wishes from the team at The Lowdown

EVERY DONATION COUNTS!

We know many readers are willing to make a contribution, but have not yet done so. With many of the committees and meetings that might have voted us a donation now suspended because of the virus, we are now asking those who can to give as much as you can afford.

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

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

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

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