The lowdown

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

Private hospital group backs out of covid deal to treat NHS patients

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

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

An exclusive article in the Health Service Journal has revealed that US-owned HCA, The London Clinic and the Cromwell Hospital have pulled out of any renewed contracts to treat NHS patients – because the fees on offer were not high enough. The private hospitals were unwilling to return to rules under the first block-booking of beds that ensured low-priority private patients were not treated ahead of NHS patients – including cancer patients – who needed surgery urgently.

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In a recent Healthcare Markets magazine interview, HCA UK chief executive John Reay indicated that, while the company was keen to "continue partnering with the NHS", its priority was restarting activity for its core private patient base, where demand was again increasing.

"Reay believes the number of patients requiring treatment, particularly for cancer and cardiac care, means HCA's hospitals will be 'full and busy'."

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

Twiddling of thumbs

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

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

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

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

A rather one-sided 'partnership'.

John Lister

Councils concerned over NHS shake-up

Key points:

- **The new reorganisation of the NHS will lead to a loss of accountability, says the Local Government Association**
- **The integration project is not fully joining up health, well-being and social care systems**
- **GPs and the mental health sector worry that they will be overshadowed by powerful acute trusts**

NHS England/Improvement (NHSE/I) has just concluded a perfunctory consultation on the details of new legislation it wants the government to enact early this year. It hopes to give legitimacy to changes that are already well advanced, establishing Integrated Care Systems (ICSs).

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

The consultation was largely unreported and lalso eclipsed by the covid crisis, so the implications of the proposed changes for local accountability, availability, and access to services are not widely understood by the public or NHS staff.

However the final weeks of the consultation have seen increasing expressions of doubt over key aspects of the plans, perhaps most conspicuously and surprisingly from the Local Government Association (LGA), a normally conservative all-party body that represents the leaders of 335 of England's 339 local authorities:

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

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

The loss of local accountability is the inevitable result of slashing the number of CCGs from almost 200 to just 42 ICSs covering England.

The LGA criticism reinforces widespread suspicion of the extent to which ICSs, which have been set up and function largely in secret, would be in any way accountable to local communities if given statutory powers.

The mergers inevitably result in bodies that are more remote from the needs and concerns of any local community. But there are also concerns over how the new bodies will function.

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

A centralising, top-down approach

Many GPs fear primary care, after playing a leading role in CCGs, would be marginalised in ICSs dominated by large acute hospital trusts.

But NHS Providers, representing trusts and foundation trusts, has also expressed reservations. "Trust leaders – and partners from across the health and care system – are cautious about any top-down, inflexible reorganisation of the NHS, particularly in the middle of a pandemic."

Even the NHS Confederation, representing public and private sector providers and commissioners, and broadly supportive of most NHSE proposals, appears to be uncertain of the future. Its commissioning wing (NHS Clinical Commissioners) warns: "The local stewardship role of CCGs and their joint working with local authorities must not be lost – we cannot throw the baby out with the bathwater." Although it's not quite clear what the 'bathwater' is in this case.

Its statement continues with a promise that appears far from confident: "We will seek to influence NHSE/I at the highest level in order to minimise disruption and destabilisation, consolidate the positive, and that way we can ensure the fantastic legacy of CCGs lives on in ICSs."

The NHS Confederation response admits that "Primary care network leaders were the least supportive of the health and care leaders we surveyed recently about ICSs becoming statutory bodies because of the level of unrest this could create at a local level."

And its Mental Health Network expressed the danger that other providers could be "overshadowed by acute sector needs", and argues that any legislation must ensure an equal footing for mental health – an issue that is conspicuously not covered in the 39-page NHSE/I document 'Integrating Care' that sets out the two options for consultation.

There is no sign NHSE/I will take note of any of these reservations. It is forging ahead regardless – 29 of the proposed 42 ICSs have already been approved by NHSE/I – even though they lack any legal status, and almost all operate behind closed doors with no public accountability. The remaining 13 STPs are required to become ICSs by April, or face the intervention of an "intensive recovery support programme".

ICSs have been driven from the top by NHSE/I, and in many areas resisted at local level by councils, GPs and campaigners.

However, 'Integrating Care' claims they are "a bottom-up response", and that the handful of early ICSs "have improved health" and "developed better and more seamless services."

In fact, as The Lowdown has reported, the improvements that have been made along these lines have been made under existing legislation.

There are also repeated references to using 'digital' and 'data' as ways of driving system working and improving outcomes.

But while there has been increased use of telephone and 'virtual' consultations during the pandemic, many vulnerable people are among the millions digitally excluded.

NHSE/I ignores this major weakness of 'digital first' approaches. Digital technology and number-crunching are among the more lucrative areas in which private companies are seeking profitable NHS contracts, not least through the Health Systems Support Framework established by NHSE/I to facilitate easy contracting by ICSs. ***JL***

From pandemic to infodemic: NHS staff battle covid deniers as well as the virus

IT'S HARD NOT to see the 24/7 transmission of disinformation swirling around the covid-19 pandemic – promoting the unhinged worldviews of lockdown sceptics, anti-vaxxers and covid deniers, all stemming from the largely uncensored transmission of 'alternative facts' on social media – as being as big a threat to public health as the virus itself.

As the director-general of the World Health Organization (WHO) put it last year, "We're not just battling the virus. We're also battling the trolls and conspiracy theorists that push [disinformation] and undermine the outbreak response."

This global 'infodemic' has grown exponentially since the threat of covid-19 first emerged a year ago, but it's by no means a new phenomenon – in the US, evidence emerged in early 2019 of anti-vaxxer activists using private Facebook groups to convince mothers not to vaccinate their children, and using social media to harass doctors who didn't share their views.

More overtly, fringe academics and oddball celebrities have proved all too keen to jump on the bandwagon to lazily confuse and mislead, on both sides of the Atlantic.

Twitter addict Donald Trump's thoughts on injecting disinfectant and bathing in UV light to recover from the virus variously amused or distressed many last year, as did Kanye West's dismissal of a potential vaccine as "the mark of the beast". Kim Kardashian's partner went on to assert, "They want to put chips inside of us."

Former Oasis member Noel Gallagher insisted in a podcast last September that, "There's too many fucking liberties being taken away from us now… I choose not to wear [a mask]." A view clearly shared a week earlier by Stone Roses frontman Ian Brown, who tweeted, "No lockdown no tests no tracks no masks no vax," before berating "the lame stream media [who] discredit those who can smell and see through the government/media lies and propaganda".

Establishment voices?

The impact of these celebrity influencers' musings – or those of more controversial covid deniers like David Icke who, according to The Jewish Chronicle, suggested that Israel was using the pandemic to "test its technology" – is hard to measure, but their collective stance has been bolstered by more articulate expressions of non-conformity emanating from seemingly establishment voices.

The former British supreme court justice Jonathan Sumption, for example, claimed last October that the UK government was behaving like an authoritarian regime when it introduced emer-

gency measures that were "the most significant interference with personal freedom in the history of our country". At pains to stress that he was no covid-denier, Sumption's opinion nevertheless surely offered a green light to all anti-mask wearing and lockdown-hating libertarians.

Fringe academics are also having some success spreading the sceptic message, gaining access to BBC outlets in the process. Sunetra Gupta – a professor of theoretical epidemiology at Oxford University and co-author of the Great Barrington Declaration (which promotes the concept of herd immunity during the pandemic), who told Investors' Chronicle last month that she was "quite mystified" that her research had been suppressed and vilified – was recently given a platform on Radio 4's Today programme to question the impact of the new covid-19 strains and the need for lockdowns.

Antisocial media

Notions of herd immunity and shielding the vulnerable are also being championed by Karol Sikora, an oncology professor at the private University of Buckingham, who has appeared on Radio 2 and Politics Live in the past six months to argue his case, which in the past has included a denunciation of the NHS as "the last bastion of Communism".

The explosion in social media use over the past decade has been the main driver of disinformation across many sectors but healthcare has been the worst affected, especially since the pandemic began, and the policies of the main service providers, wittingly or otherwise, are still enabling this phenomenon.

At the beginning of December Facebook appeared to change its tune, announcing it was to ban debunked claims about the safety of vaccines being used against the covid-19 virus, but only last week The Guardian reported that some accounts on the site were still promoting falsehoods relating to those vaccines, and that prominent anti-vaxxers banned from Facebook had simply switched to using Instagram, which is owned by… Facebook.

And, in the past ten days, one Facebook group has featured images from videos filmed undercover by covid deniers and lockdown sceptics at more than 30 hospital and testing sites across England and Northern Ireland. The footage – shot mostly in deserted outpatient or reception areas, and often at night – was part of an apparently co-ordinated campaign to 'prove' that the NHS is not under pressure.

This despite statistics from Public Health England currently showing positive test results surging, a daily covid-related death rate of more than 1,300 and almost 32,000 infected patients occupying hospital beds – and also despite 'major incidents' being declared at hospitals across the South East in the past week.

One popular claim among sceptics is that there is little photographic evidence of patients suffering from the virus. But one NHS consultant – Dr David Oliver, who has worked on a covid ward for the past six months – told The Lowdown that even footage by teams from the BBC and ITN has failed to convince the deniers he regularly encounters on Twitter of the severity of the pandemic, with some even suggesting that the patients, doctors and nurses featured were merely actors.

"The idea that deniers should have direct access to covid wards – ignoring infection control measures, compromising confidentiality and upsetting relatives – to get some sort of 'proof' is just insulting to the families of people on those wards," said Dr Oliver. "But the threat is always there that deniers will try – hospitals are of course huge, public buildings, too big to police.

"The problem is that these people have a disconnect with reality, nothing will convince them – they won't believe the statistics, they can't cope with facts. We even had one patient – who almost died – telling us he didn't believe the virus existed."

One issue identified in a paper on online disinformation two years ago – by Data & Society founder Danah Boyd – was that of 'data voids', spaces on the internet where an absence of regularly updated and reliable content allowed conspiracy theorists to populate those spaces with disinformation.

Exploiting anxieties

In the US, the Center for Countering Digital Hate has been monitoring the activities of anti-vaxxers during the pandemic, clearly keen to exploit those data voids, and noted that leading activists held a private online conference last year on strategising public anxieties to undermine confidence in vaccines.

The concept of 'vaccine hesitancy' stemming from online disinformation is well-established, having been identified by the WHO two years ago as one of the ten greatest threats to global health, and its influence is already evident in countries like France, where a recent Ipsos survey found that only 40 per cent of the population would get a covid vaccine when it became available. French Facebook group Les Vaxxeuses, set up by scientists to counter fake news, even found claims on social media that covid vaccines would turn patients into genetically modified organisms.

Martin Shelley

For perhaps the best point-by-point rebuttal of the current wave of disinformation surrounding the pandemic, The Lowdown recommends readers check out an excellent piece in The Guardian, published just last week, and written by Jeeves Wijesuriya, a junior doctor working at a London hospital and a member of the Healthcare Workers' Foundation.

New plan urgently needed to cope with surge in mental health problems

Key points:

- **Covid-19 could lead to new or extra mental health support being needed for 10m people**
- **Research shows the number of men having suicidal thoughts has doubled in ten years**
- **Charities and unions criticise lack of action and call for more realistic funding to train and recruit extra staff**

AS THE COUNTRY entered lockdown three it is clear that covid-19 has created a new wave of mental health problems, adding to the burden on services, and resulting in calls for longstanding issues to be finally addressed.

According to an estimate by the Centre for Mental Health, 10m people (almost 20 per cent of the population) will need either new or additional mental health support as a direct consequence of the pandemic, with 1.5m of those children and young people under 18. This was probably an underestimate at the time.

This is a huge number of people that will need support – some perhaps for weeks, others for many years to come.

Already in crisis

The pandemic is amplifying a long-term trend in rising mental health distress. The latest perspective on that comes from a survey by mental health charity Mind, in association with the English Football League, released earlier this month, which found that in the last ten years the number of men having suicidal thoughts had doubled, and there were worrying increases in the use of negative coping mechanisms, such as drinking alone and taking recreational drugs.

"Policy is still being undermined by a fundamental lack of public sector capacity"

Before the pandemic NHS mental health services were already in crisis.

One in four people with mental health problems were waiting three months to start NHS treatment, and some did not get help after four years, according to research published in October last year.

Services were struggling with demand after years of underfunding, the criteria for treatment referrals were tightening, leaving many patients struggling to get help. Some patients are being sent miles from home for inpatient care, and hospitals and community teams are struggling to recruit staff.

In September last year vacancies in mental health stood at 19,000, down by 3000 in a year, but there is still a massive shortfall in the staffing, becoming ever more urgent with the covid-driven escalation in demand.

Calls for more funding

Before the pandemic, mental health services had received a funding increase, but by nowhere near enough to improve services and recruit and train the staff needed to cope with demand.

Back in January last year, the British Medical Association (BMA) appealed for at least a doubling in funding over the period of the long-term plan (from 2019/20). Overall mental health spending in 2020/21 stood at £14bn, so this would mean a rise to more than £25bn by 2025.

Following on from government initiatives and reports that claim to usher in a new dawn in support and a higher prioritisation of mental health, it would be untrue to say that there has been no progress, but calls from organisations representing staff and patients expose the reality that policy is still being undermined by a fundamental lack of public sector capacity.

Now with a growing wave of mental health illness already upon us, one would expect the government to be investing heavily in both facilities and staff. In mid-2020, the BMA called for several actions by the government to equip and fund mental health services to enable them to cope with demand, including once again asking for a doubling in funding for mental health services and making recruitment and retention of mental health staff a priority for the NHS.

In August, Andrew Molodynski, BMA mental health lead, said that although mental health services are not currently ready for such a surge in demand (and perhaps never have been) "hope is not lost" if actions are taken now to prepare mental health services to help those in need.

Wiser voices being heard?

In the last spending review in November, however, there was little that could be said to really tackle the challenge of mental health services. Rishi Sunak gave around £500m to address waiting times for mental health services; £165m capital funding ring-fenced for 2021-22 to replace outdated mental health dormitories with single en suite rooms; and £4.3m to be used for green social prescribing.

This comes to around £670m and, as Mind's head of policy and campaigns Vicki Nash said: "[The funding] is some way short of estimates that due to increased demand mental health services will require more than £1bn a year for the next three years, to deal with the long term fall out of the pandemic."

"The pandemic is amplifying a long-term trend in rising mental health distress"

Some funding has gone to charities, including a £27m recruitment drive launched by mental health charity Think Ahead, which will recruit and train up to 480 mental health social workers, and a £46m scheme to provide more effective and coordinated support for vulnerable people.

While mental health services now compete for funding far more successfully and government policy is to some extent being influenced by wiser voices from within the sector, the government must grasp the need for a new plan to lift NHS mental health capacity to levels where we can truly guarantee access to mental health care for all.

It's nearly Christmas – time for a new NHSE list of tasks

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

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

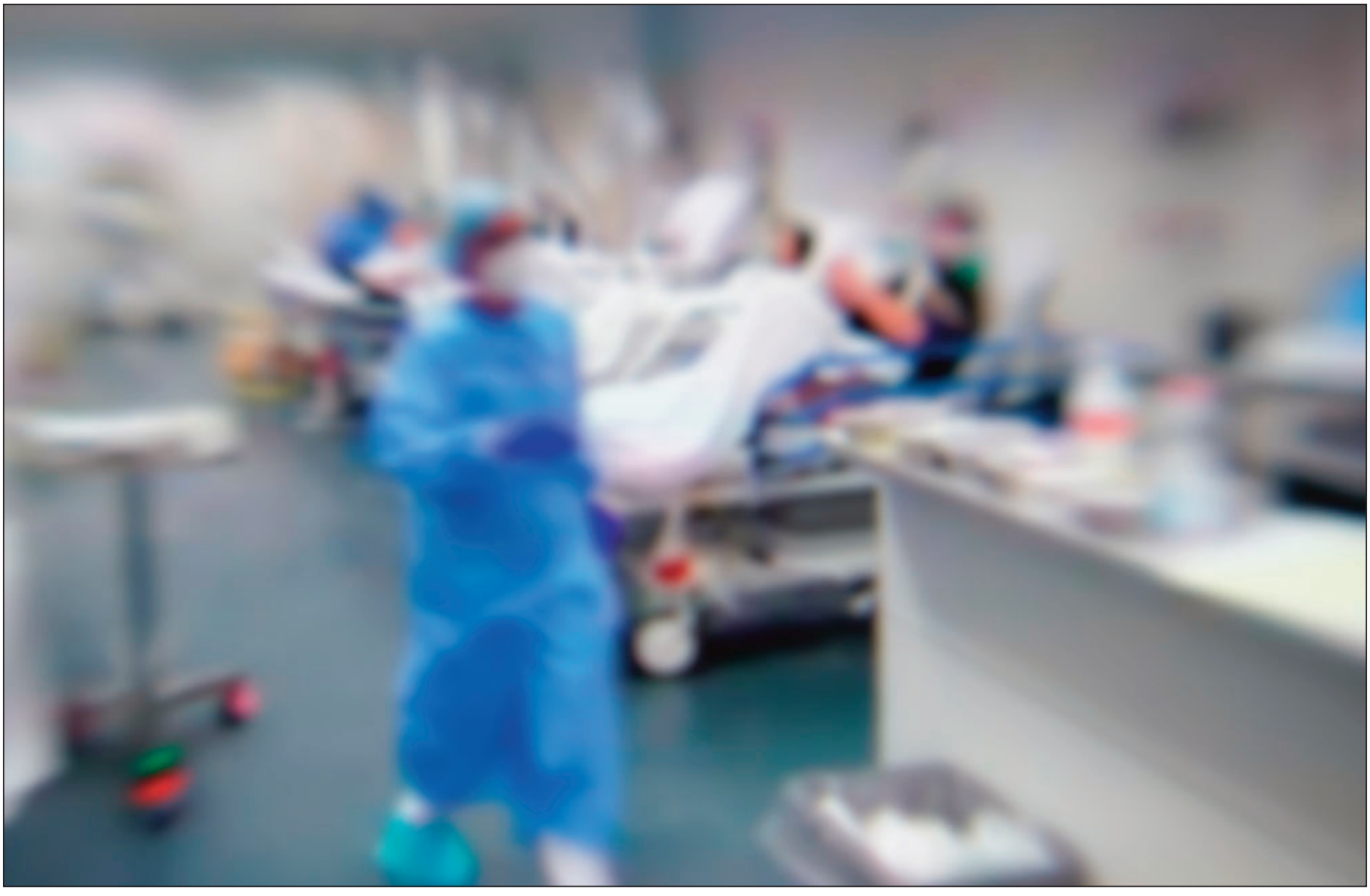
The letter varies on the 'shit sandwich' formula of prefacing and following tough instructions with positive statements, and opts instead for the 'shit piecrust' approach, beginning with a paragraph that recognises some unsung achievements of a difficult year: "The number of cancer treatments is above the level at the same time last year. GP appointments are back to around pre-pandemic levels. Mental health services have remained open and more than 400,000 children have accessed mental health services, above the target for 2020/21. Community services are supporting 15 per cent more people than they were at the same point last year... It has been an incredible team effort across our health and care system."

But from there it goes rapidly downhill. Roy Lilley of nhsmanagers.net has mocked the letter's redundant instructions such as "… maintaining rigorous infection prevention and control procedures continues to be essential" and "minimise the effects of emergency department crowding".

Implausible and impractical

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

But surely the most implausible and impractical proposal is the one highlighted by the HSJ report: "… we will set an aspiration that all systems aim for top quartile performance in produc-



tivity on those high-volume clinical pathways systems tell us have the greatest opportunity for improvements: ophthalmology, cardiac services and MSK/orthopaedics."

Top quartile productivity is by definition not attainable by all, any more than all trusts can be above average. And while ophthalmology and orthopaedics might possibly be able to maintain covid-free services, it's unlikely many cardiac services will be able to do so in competition with the expanded bed provision for covid patients.

Pritchard and Kelly go on to confirm that while the government has provided "an additional £1bn of funding for elective recovery in 2021/22", NHS England bureaucrats have yet to work out how to spend it: "In the new year we will set out more details of how we will target this funding."

A good lump of this money is set to go to private hospitals: the letter stresses the importance of "maximising use of the independent sector" as well as use of "funded additional facilities such as the Nightingale Hospitals" (most of which have not been staffed or more than fractionally used). They also urge "Timely and safe discharge … making full use of hospices" – two thirds of which were facing financial crisis and redundancies last October and pleading in vain for extra government funding.

Private sector to the rescue?

With no corresponding focus on maximising use of NHS beds, the emphasis on using private hospitals (now coyly referred to as "IS providers") emerges again with the revelation that "… we have also extended the national arrangement with the independent sector through to the end of March, to guarantee significant access to 14 of the major IS providers. If you need it, we can also access further IS capacity within those providers subject to the agreement of the national team."

The letter requires all Clinical Commissioning Groups and trusts to: have a senior responsible officer to lead the EU/UK transition work, while trust boards are also expected to review maternity services against the 12 urgent clinical priorities of the Ockenden Review (of Shrewsbury and Telford); appoint a board-level executive lead to prepare system-based recovery plans and outpatient transformation; audit progress against eight urgent actions to tackle health inequalities as set out in a 31 July letter; and to top it all, systems and organisations – working flat out to treat covid patients and deal with winter pressures – "should start to develop plans for how covod-19 costs can be reduced and eliminated once we start to exit the pandemic."

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

John Lister

Brexit deal limits damage to the NHS, but where's the benefit?

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

Early in December a leaked government document had spelled out a 'reasonable worst case scenario' if no deal were signed, which included warnings of public disorder, shortages of fuel, rising food prices, and initial reductions of up to 40 per cent in supplies of medicines and medical products for the first three months.

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

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

Worsening a chronic shortage

The axing of freedom of movement will therefore have its most brutal impact on the care for frail elderly residents in increasingly under-staffed care homes, especially in parts of south-east England where up to 30 per cent of care staff have been recruited from EU countries. Patel's hard line legislation also blocks recruits from non-EU countries, worsening a chronic shortage.

The Nuffield Trust's programme lead Mark Dayan, has warned that the new rules, which Patel had already announced for 1 January, would hit social care especially hard, noting that the problem is of the British government's own making: "Ulti-

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mately the migration system is now a free choice for Britain: if we want the functioning, protective, social care system the Prime Minister has promised, we may need to choose differently."

An additional longer term problem highlighted by the NHS Confederation is that the Brexit deal ends mutual recognition of professional qualifications. While the UK (in need of professional staff) has unilaterally decided to continue to recognise European Economic Area (EEA) qualifications for up to two years, the EU has made no equivalent concession. This will limit British-trained professionals from developing their skills and research by taking up posts in EU countries.

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

Delays and disruption

Barts Health, one of the biggest NHS trusts, has more than 1,700 staff from the remaining countries of the EEA. Barts issued a statement on 31 December, warning that the end of the transitional period means all EU citizens who were resident in the UK by that date will need to apply to the EU Settlement Scheme (EUSS) to continue to live, work and study by 30 June this year: "This also applies to their family members including children and non-EU citizens. You may be asked to provide relevant documents to confirm your status in the UK in order to establish your entitlement to free NHS hospital care."

With 75 per cent of the medicines used by the NHS and half of all medical devices for the UK coming from the EU, many experts, industry leaders, health bosses and even members of the Government, have acknowledged that disruption at the border will be an inevitable consequence of the UK leaving the EU.

The letter to health and social care leaders from Health Minister Edward Argar admits the probability of delays:

"We are working with suppliers to help ensure adequate mitigations are in place for non-clinical goods and services (for example, hospital food, laundry, IT contracts etc). … Adult social care providers … should continue to get covid-19 PPE via the PPE portal. You should allow more time for non-clinical goods to arrive – an extra 72 hours where you rely on 'just in time' supply chains."

The trade deal only covers goods, not services, leaving doubts over many high technology products such as medical scanners which are supplied as a bundle with operating or maintenance contracts. Any disruption of maintenance or supply of components could threaten the ability of hospitals to deliver care.

Perverse decisions

Meanwhile more decisions made by the British negotiators are likely to limit and delay British awareness and response to further health threats. While the UK and EU will "collaborate/cooperate in warning each other and tackling health threats", the NHS Confederation warns that the UK "will not normally have access to EU databases and will not retain membership of the European Centre for Disease Prevention and Control." And the UK will in future need to "request access to the EU's Early Warning System" to tackle a specific threat. Nobody has explained these perverse British decisions.

The government also decided to pull out of the European Medicines Agency (EMA) which used to be based in London: as of last February no one representing, appointed by or nominated by the UK can participate in any EMA scientific-committee or working-party meetings, or in the agency's management board. Now it is no longer part of the EU or its pharmaceutical regulatory structure it's likely Britain will no longer be seen as a first priority launch market for new drugs.

So while the worst aspects of a no deal exit have been avoided, there is little if any sign of any up-side to Brexit for the NHS, and the full implications have yet to unfold. As NHS Confederation chief executive Danny Mortimer summed up:

"NHS leaders will be flooded with new rules, guidance and information and be required to make significant adjustments at breakneck speed – all while dealing with unprecedented covid-19 and winter pressures. While the preparations for the NHS are as good as can be, the circumstances could not possibly be worse."

IBMS: 'Vital that megalabs have appropriate skill mix'

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

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

"We have evidence that recruitment agencies working for the Lighthouse labs have been directly approaching biomedical scientists working in the NHS to offer them enhanced salaries to tempt them to leave the NHS. It is a concern that instead of working with the professional bodies and the existing pathology community to explore how these new mass testing labs could be staffed and run as extensions of the existing pathology labs, the government has chosen to engage with a recruitment agency with no pathology experience."

"We would not allow unregistered staff to run care in clinical settings such as medicine, nursing or radiography. Why are labs being viewed as 'different'?"

Difficult to predict

Asked whether it seemed likely that the new mega lab – unlike the Lighthouse Laboratories, which were set up in parallel with the existing NHS laboratories – would be properly accredited and regulated, Allan Hall replied: "It is difficult to predict at this stage. There is a glimmer of hope as a meeting took place this month between the IBMS CEO and deputy CEO and representatives from Deloitte, which is also closely involved in getting the new mega labs up and running.

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

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

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

Future role?

Following the Department's failure to communicate with the IBMS over the Lighthouse labs there had been some signs of a change of attitude:

"We now have monthly meetings with NHS England/Improvement and have a clearer idea of the testing strategy and the role of the Lighthouse labs – we had a meeting last month with Lord Bethel and Dame Anna Dominiczak who is the lead for the Lighthouse labs. I also visited the Glasgow Lighthouse lab at the beginning of the month.

"My main concern is that Mr Hancock sees the future role of the Lighthouse labs as a part of the NHS diagnostic capacity. The Lighthouse labs are designed to industrialise a single test and not a flexible, complex multi-faceted pathology service.

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

John Lister

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