The lowdown

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

Frameworks for secrecy – and private profit too

A seemingly endless succession of large-scale 'framework agreements' has been rolled out by NHS England and the Department of Health & Social Care in recent months, creating the conditions for more rapid awarding of contracts with a pre-authorised shortlist of private, public sector and not-for-profit providers, with limited – if any – further competitive tendering.

Recent examples include a £500m facilities management framework, an £800m framework for a range of health IT services, a £10bn "open opportunity" to reduce waiting times, and a massive £47bn construction framework.

It is possible to trawl through the general terms of these agreements, and also to check out the NHS Shared Business Services (SBS) list of almost 1200 approved organisations that have access to the SBS portfolio of framework agreements, and can use any of them as and when required.

But what do the framework agreements look like at the local level, when a hospital trust signs up with one of the pre-approved providers and agrees a contract for a specific set of tasks?

No contest – congrats!

"The recent publication of one contract gives a glimpse of just how opaque and secretive these deals can be"

Rutherford/SFT link up

Light on details

The recent publication of a contract for the "provision of mobile and strategic clinical solutions and associated goods" – between Somerset NHS Foundation Trust (SFT) and the private oncology services provider Rutherford Health (and its subsidiaries Rutherford Diagnostics and Rutherford Infrastructures) – gives a glimpse of just how opaque and secretive these deals can be.

Rutherford's chief medical officer is one of the media's favourite private doctors, Karol Sikora, who famously claimed on the BBC in 2017 that the NHS was the "last bastion of communism" and needed a "total rethink".

Such scruples obviously do not stop Rutherford from eagerly hoovering up cash from NHS hospital contracts, although they do seem more than a little shy of revealing any details. The contract was only published at all in response to a Freedom of Information Act request to SFT but, as with so many documents grudgingly released by secretive management, the 97-page contract has been heavily redacted to remove almost any useful information.

Blacking out

All of the content – and sometimes the whole page – has been completely blacked out on 28 pages, including the last 18. All detail of penalties in the case of failure to deliver has been expunged from pp49-50 and pp70-71, as indeed has any information on the key performance indicators (ie basic contract requirements) for the supplier (page 68), and all the detail on the company handling private patients on behalf of SFT (p41).

Many pages have been so heavily edited it is impossible to deduce what has been removed from public view, but it is clear that all of the details relating to the quantity and cost of the services (p13) and milestone dates of the implementation plan (pp20-21) have been blacked out. Even the date of the agreement has been obscured on p51.

With so much of this agreement apparently embarrassing to one party or the other, it is hard to avoid the conclusion that this and many similar framework agreements are funnelling substantial and disproportionate profits to private providers while trust bosses hide from any public accountability. And that the NHS budget is being more systematically milked for private profit.

John Lister

The puzzle of the private beds

Hospital beds: lack of transparency over block-booking of private capacity

The latest available NHS England (NHSE) figures (dated 3 September) show that, of available beds open overnight, an undifferentiated 110,000 beds of all types – general, acute, mental health, maternity and learning difficulties – were occupied.

This appears to be close to the average of just 112,000 beds that were occupied in the equivalent period of 2019 before the impact of covid-19.

However unlike 2019, when all of the bed numbers were from NHS and foundation trusts, the most recent figures show that 5,369 – nearly 5 per cent – of the total were private sector beds, at least 3,000 of which were from identifiable mental health providers.

Poor value

So it would seem that even as the trusts worked to increase their activity, only 2,300 of the undisclosed total of private hospital beds block-booked by NHSE to increase capacity for urgent and elective acute services were being used in the weeks leading up to early September.

While suspicions will run high, in the absence of any transparency or official data – on the scale and terms of the actual block-booking arrangement, the proportion of booked beds actually used for NHS patient care, and the amount actually paid – it is impossible to tell whether or not this is value for money.

"While suspicions run high, in the absence of any transparency or official data it is impossible to tell whether or not this is value for money"

However what is clear is that NHSE's letter dated 31 July states it is expecting local trusts to make plans including the use of private sector beds, and to show these plans to NHSE so that, in order to "ensure good value for money for taxpayers, systems must produce week-by-week independent sector usage plans from August, and will then be held directly to account for delivering against them."

Follow the money

On p7 of the letter, NHSE goes on to refer to the "£3bn [of] NHS revenue funding for ongoing independent sector capacity".

So will any of these plans – or any figures to show how much public money has been spent, and what private sector capacity was secured and actually used during the period of this deal – ever be published?

Without any reliable facts proving the contrary, many will fear that huge sums have been paid out to prop up a parasitic and financially troubled private hospital sector for relatively little benefit, while thousands of NHS beds have remained empty or under-used.

The latest proposal for private hospitals to be used for the training of junior doctors – which will consolidate not only the use of the beds but the regular use of NHS staff to deliver NHS-funded operations from private hospital sites (and therefore separating them from the staffing available in local NHS trusts) – seems set to consolidate this method of working.

Of course the training of new medical staff will remain entirely an NHS responsibility: private hospitals train no medical or nursing staff and contribute nothing towards that training, while they rely heavily on NHS- and overseas-trained staff to deliver their limited range of services.

Number of tests for suspected cancer has dropped by 75%

Diagnostic backlog 'hub' plan revealed

Plans to address the growing crisis in cancer diagnosis and treatment – caused by a drop in referrals since the pandemic began earlier this year – were recently revealed in a document leaked to online news site HSJ.

According to the document, NHS England (NHSE) is planning to create at least 150 'community diagnostic hubs' to help clear the ballooning waiting lists that have built up while the health service withdrew care from non-covid patients to focus on coping with the impact of the virus.

However, the document contained no details of additional funding to finance this plan, despite the pressing need to restore provision of cancer diagnosis to pre-pandemic levels.

With existing screening programmes effectively suspended across the UK – meaning 210,000 fewer people are being scanned each week – the resulting backlog of cancer care has already impacted nearly 2.4m people just through a lack of urgent referrals. In England alone, the number of people being referred for diagnostic tests for suspected cancer has dropped by 75 per cent, leaving more than 55,000 people waiting for appointments.

Under the new plan, during the approaching winter months the diagnostic hubs will use the existing NHS estate, along with locations provided by the private health sector, but in the longer term – from spring 2021 – it is expected many of the hubs will be set up in non-traditional environments such as high streets and retail parks.

"The well-established presence of private sector interests in the diagnostic arena suggests there may be rich pickings on offer"

And NHSE expects the hubs to operate for up to 14 hours a day, seven days a week, although it acknowledges these performance targets may initially be unachievable because of "workforce constraints", indicating it is possibly all too aware of a national shortage of radiographers and radiologists. National charity Cancer Research has already reported that one in ten diagnostic posts were unfilled when the pandemic began.

Aside from manpower issues, the impact of the new programme may also be blunted by the worsening MRI equipment base of the NHS following years of under-investment. According to OECD data the UK has one of the lowest numbers of MRI systems per head of population, and the Clinical Imaging Board claims that nearly 30 per cent of the UK's MRI stock is at least ten years old.

Whether the new hubs become permanent fixtures is unclear, and references to high street and retail park sites aren't necessarily a sign of encroaching commercialisation, but the well-established presence of private sector interests operating in the diagnostic and pathology arena suggests there may be rich pickings on offer somewhere, if only until the backlog is cleared.

Existing research by the NHS Support Federationshows that the privatisation of diagnostic and pathology services is well under way, with several companies already holding large long-term contracts with the NHS – every aspect of diagnosis is now carried out somewhere in the UK by a private contractor.

In fact the oldest partnership between the NHS and a private company in diagnostics and pathology is Viapath, a joint venture between two major hospital trusts and outsourcing giant Serco.

So when, in late July (before the leaked document published by HSJ), NHSE chief executive Sir Simon Stevens pledged to restore full operation of all cancer services, it was perhaps no surprise that he stressed this work would be overseen by a taskforce of "major patient charities and other key stakeholders" who would ensure sufficient diagnostic capacity, "including through the use of independent sector facilities".

Martin Shelley

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New figures show up to 26% of CCG cash spent on non-NHS healthcare

On average, clinical commissioning groups (CCGs) spend around 15 per cent of their budgets purchasing healthcare from non-NHS bodies, but an NHS Support Federation survey of their 2019-20 annual accounts also shows 18 CCGs spend around 20 per cent, with the highest spenders allocating as much as 26 per cent.

The recipients of this largesse include community interest companies (also known as CICs or not-for-profits) and charities, as well as countless private ventures.

But not all outsourcing expenditure is reflected in these figures. CCGs record their spending on GP surgeries separately, some of this will include 'alternative provider medical services' (APMS) contracts signed with companies paid to run local surgeries – such as those with AT Medics and Virgin Care – and so the true level of spending will be even higher.

Community health: the basis of many contracts

Community service

So what care are CCGs buying in? Of the top ten spending CCGs a common factor was the large scale outsourcing of community healthcare – services that are not covered by GP contracts or carried out within hospitals. These large contracts often also cover public health services, which are funded by local councils.

Coming top of the big spenders is Bath and North East Somerset CCG (now merged to become Bath and North East Somerset, Swindon and Wiltshire CCG) with non-NHS recipients accounting for 26 percent of its net expenditure.

This comes as no surprise, as in November 2016 it awarded Virgin Care a seven-year contract worth around £700m for provision of more than 200 community health services. This contract crosses over into social care, and includes adult social care, continuing healthcare, children's community health, public health nursing, and speech and language therapy.

This is a prime provider contract with Virgin Care directly delivering and coordinating services, but with the option to subcontract to other providers where appropriate.

Another high spender, at 22 per cent, is West Lancashire CCG, which also has large contracts with Virgin Care for community health services and urgent care services. Virgin Care was awarded two five-year contracts together worth £65m in December 2016 and they began in April 2017. The services include district nurses, community matrons, IV therapy, end-of-life teams, GP out-of-hours and walk-in centres.

"Spending on services run by non-NHS organisations is more than double the percentage reported by central government"

Charitable intent?

The remaining high spenders in the top ten have in common a large number of contracts (or just a single large contract) with a CIC, many of which were spun out of primary care trusts in 2008. They are run like any other company, but profits are ploughed back into services or through a charitable subsidiary.

Mid-Essex CCG has major contracts with Provide, a CIC that provides community services (district nursing, speech and language therapy, podiatry, community hospitals, community stroke and rehabilitation services) but also has a contract with the private company Integrated Care 24 for integrated urgent care (including NHS 111 and out-of-hours GP services).

Greater Huddersfield CCG and North Kirklees CCG both have contracts for a large number of community health services with Locala, a CIC.

Other high-spenders include: North East Lincolnshire CCG, with a contract with CIC NAViGO for community mental health; Hull CCG, which has outsourced community health to City Health Care Partnership CIC; Medway CCG, with community health provided by Medway Community Healthcare CIC; Nottingham CCG, with community health handled by Nottingham CityCare Partnership CIC; and East and North Hertfordshire CCG, where Herts Urgent Care CIC provides urgent care and NHS 111 services in the area.

Top ten CCG purchasers of non-NHS healthcare in England

BNESSW*
Mid Essex
Greater Huddersfield
BNSSG**
North East Lincolnshire
Hull
Medway
Nottingham City
West Lancashire
North Kirklees

**Bath & NE Somerset, Swindon & Wiltshire*
***Bristol, N Somerset and S Gloucestershire*

Then there's East Surrey CCG, with community health provided by First Community Health & Care, on a contract recently renewed without a competitive tender process.

Overall, our assessment of CCG annual accounts in England shows spending on services run by non-NHS organisations to be more than double the percentage reported by central government, and possibly higher still if spending on GP services could be included.

Privatisation is also not going away, as the £1.06bn contract with Sirona shows *(see below)*.

Molly Dawson, Sylvia Davidson & Paul Evans

Case study: Sirona

The best example of the dominance of a CIC in community health is in the Bristol, North Somerset and South Gloucestershire CCG area. In 2019/20 this CCG spent 23 per cent of its budget on non-NHS groups, but this is likely to rise even higher after awarding a ten-year, £1.06bn contract to Sirona CIC, which began in April.

Sirona has been providing community healthcare – adult and children's – in the area under several smaller contracts for several years, often in partnership with the local hospital trusts and other CICs. But Sirona will now also provide public health services funded by local councils.

Sirona has also gradually taken over children's community health services in the area. Under a five-year contract worth £34.6m annually, which began in 2017, Sirona runs children's services across Bristol and South Gloucestershire, and covers health visiting, school nursing, child and adolescent mental health (CAMHS), community paediatricians and community nursing.

Then in January this year Sirona took over the contract for specialist children's community health services in North Somerset, previously run by Weston Area Health NHS Trust which withdrew from the contract. Sirona scooped the contract without a tender process taking place.

Under all its contracts, Sirona is listed as a prime provider, which allows it to sub-contract services to other organisations, which could be the local NHS hospital trusts.

Sirona has sub-contracted CAMHS to Avon & Wiltshire Mental Health Partnership NHS Trust (AWP), in Bristol and South Gloucestershire for a number of years and from April 2020 will sub-contract CAMHS in North Somerset to AWP.

CICs with their promises of re-investment of profits and strong community base, are often viewed as somehow having a more benign influence on the NHS than shareholder-driven private companies, such as Virgin or Care UK.

Yet Sirona has recently exhibited behaviour that private companies have been criticised for – such as asking extra for contracts and walking away if they're financially unviable.

In April 2019, the local CCG accused Sirona of "burying its head in the sand" over failures to assess vulnerable children across Bristol and South Gloucestershire under a contract to provide initial health assessments (IHAs).

Sirona was supposed to provide IHAs for 90 per cent of looked-after children but it achieved just 7 per cent – nine out of 123 – in the city over the last 12 months, according to its own figures. And in South Gloucestershire, that figure was just with 24 per cent – 12 children out of 50.

The company insisted it needed more money as funding had been reduced and requested £155,000 for three extra specialist nurses. But the local CCG dismissed the request, as funding had not been cut and there had actually been a 4 per cent drop in the number of children in care.

And then last September Sirona walked away, claiming lack of financial viability, from a residential and extra care services contract in Bath and North East Somerset, which have all now been taken over by the local council.

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Covid-19 testing: promises, promises

Brushing aside criticism, Boris Johnson has made a bold new promise to raise testing capacity to 500,000 by the end of October and then to leap to "literally millions" of tests a day in a "moonshot" bid powered by new technology, but ministers admit new the test doesn't yet exist, and as reports of testing delays mount, so do calls for the prime minister "to fix the current system" first.

The current system

The backbone of the current testing operation are seven non-NHS and commercially run 'super labs', built from scratch in the past few months and supported by the existing network of public laboratories. They process all the swab tests sent from test centres, or from people using home test kits.

Facilities have expanded more rapidly in the past three months to achieve the current capacity of around 180,000 tests per day, but from the outset the government was slow to follow WHO advice to step up lab testing, reaching only 5000 tests a day by lockdown on 23 March.

Critics say the government took too long to decide on a strategy. Public health labs have suffered historic cuts and the decision to opt for a privatised network instead of funding the existing NHS and academic network was controversial.

Sir Paul Nurse, Nobel laureate and director of the Francis Crick Institute in London, called it "a tactical error in my view, because it was self-evident from the beginning that a locally managed solution would have been effective."

But ministers wanted more control, and so despite the recent expansion, and with a possible second wave approaching, testing services are now being overwhelmed by demand.

Across the country people report being sent long distances for the nearest available test, being denied home testing kits, turned away from testing centres and waiting longer for the results.

"Critics say that the government took too long to decide on a strategy. Public health labs have suffered historic cuts and the decision to opt for a privatised network instead of funding the NHS and academic network was controversial"

A "heartfelt apology" from the head of the NHS Test & Trace programme included an admission that lack of lab capacity is the "pinch point".

As the current set-up struggles to handle 200,000 tests a day, the government's latest pledge of 500,000 a day by the end of October is exactly what we need, say health experts fearing the coming winter and flu season, but details of how it will be achieved are scant – although a new laboratory is due online next month.

Mass testing dilemma

At the present the government is telling people not to book a test unless they have clear symptoms. However, we know that around 80 per cent of people who contract the virus never show any symptoms. Also, as schools return, parents are already trying to determine whether their child has symptoms of covid or simply a cough or cold, and only a test can definitively tell.

The government claims that mass testing is their objective and the high demand for testing shows that many parts of society need an effective testing service to feel safe to return to work and to school.

Paul Whiteman, general secretary of the National Association of Head Teachers (NAHT), has said, "The government assured us this would be ready, but at the first sign of stress it seems to be falling over. This will put the successful and sustainable return to school at serious risk."

The moonshot

Faced with growing criticism the PM is now banking on a "moonshot" idea, a pregnancy-style test, that could deliver results in minutes to millions of people every day, enabling them to move

around in the knowledge they are not infectious.

A pilot is due to start in Salford next month. Scientific opinion accepts the concept as workable, but remains to be convinced about the validity of the proposed test and the time that it will take to develop its effectiveness. And even then, there could be a high number of false positives.

In fact, haven't we been here before? In March Johnson offered a similar tantalising vision of an antibody test that will allow us to find out whether we had developed immunity to the virus and could free up the community to move around normally. Officials spent £16m on the his "game changer" test with two Chinese firms, only to be told it didn't work, producing poor accuracy and high numbers of false positives.

This week, leaked papers to the British Medical Journal reveal government plans to spend up to £100bn on the new rapid test if it is developed and adopted widely.

The government is eager to invest huge sums, but many are questioning the strategy and asking what could they have achieved by earlier investment in the existing public health network?

Who analyses the tests?

Based on figures published by the government for the first week in September, around 60 per cent of lab tests are being provided by commercial outfits, whereas 40 per cent are being delivered by the NHS. Both have vastly stepped up their capacity, the NHS delivering around 50,000 tests a day, five times the number it could at the beginning of April. Where commercial labs have gone from less than 1000 a day to over 115,000.

The government has backed the private sector as its key partners, opting to create seven new centralised super labs – the Lighthouse network, instead of expanding the existing NHS equivalent of 44 local labs.

Private partners Astra Zeneca, Randox and PerkinElmer lead four of the Lightouse labs in Cambridge, Antrim, Newport and Loughborough. Non-profits Bio Centre and Medicines Discovery Catapult run the Milton Keynes and Alderley Park labs, while Glasgow University leads the Scottish Centre. Cambridge, Loughborough and Dundee universities are also local partners.

"The government is eager to invest huge sums, but many are questioning the strategy and asking what could they have achieved by earlier investment in the existing public health network"

NHS staff frustrated

Back in April NHS scientific staff in south London contacted The Lowdown to express their frustration that while they have the capacity to process large numbers of tests, the NHS labs struggle to get supplies of the kits and the reagents needed.

"I am so annoyed about this testing fiasco," said one. "I want to know why the new 'super labs' have been set up, because if they gave the NHS labs the resources they could easily do the tests. Our lab has been ready for ages to do large numbers of tests. We have the equipment, and we have staff.

"We could do up to 5,000 tests a day if we really pushed, and people are willing to do extra nights. But we can't get the bloody kits! Public Health England and NHS England and some other body are in charge of kit allocation and it seems they're saving them all for the super-labs."

History of neglect

Covid has proved a harsh critic of previous government health policy and here it has exposed the prolonged underfunding and privatization of public health laboratories.

Valerie Bevan, chair of the British Society for Microbial Technology, wrote to the Guardian to highlight the impact of cost saving measures. She told them "...between 1946 and 2003 the Public Health Laboratory Service (PHLS) provided a network of over 50 laboratories that were the first line of defence in major public health outbreaks. Had this network been maintained, there would have had been more laboratories available. Instead, since 2003 this network has been dramatically reduced in favour of centralisation as a cost-saving venture, which has resulted in a lack of capacity for large-scale testing."

Professor Brian Duerden the last medical director of the PHLS, told the Telegraph, "I was saddened and concerned by the loss of this national coverage. Public Health England (PHE) runs the remaining laboratories, but it does not have the same capacity."

For a longer version of this article please visit our website a https://lowdownnhs.info

Paul Evans

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Default position: discharge today

New rules may see rise in urgent readmissions

The Department of Health & Social Care's (DHSC) 21 August guidance to hospital trusts goes further than previous such advice in spelling out the need for additional government funding of "post discharge recovery and support services" to cease after the maximum six-week period after patients have been hurried out of hospital.

The whole focus is on speeding the process and minimising the numbers of patients deemed eligible to remain in a hospital bed by strict implementation, in twice-daily ward rounds, of a draconian checklist of "criteria to reside in hospital".

This entails determining whether each patient:
– requires ITU or HDU care
– requires oxygen therapy/NIV
– requires intravenous fluids
– requires intravenous daily meds more than twice
– has a National Early Warning Score of 3 or more
– has a diminished level of consciousness where recovery is realistic
– has acute functional impairment "in excess of home/community care provision"
– has undergone lower limb surgery within 48 hours or thorax-abdominal/pelvic surgery within 72 hours
– is in the "last hours of life"

If the patient does not fit at least one of these categories, and regardless of their social circumstances, the policy states they must be discharged "as soon as they are clinically safe to do so" to a "designated discharge area" within an hour, or at most on the same day, and where possible discharged from the discharge area as soon as possible, "often within two hours".

"The whole focus is on speeding the process and minimising the number of patients deemed eligible to remain in a hospital bed"

A whistle-stop process

Hospitals are required to give reasons for any delays to this whistle-stop discharge process, because the guidance states, "The default assumption will be 'discharge home today'."

Senior geriatricians have warned that the guidance could prompt an increase in urgent readmissions, permanent disability and excess mortality, while charities say families could be left with unsustainable caring responsibilities because of the new rules.

Since the peak of the covid-19 response, this policy, which emptied tens of thousands of NHS beds, has been linked with a suspension of data collection on 'Delayed Transfers of Care', and to additional government funding to cover up to six weeks of recovery and support services.

This funding could also be used "for urgent community response provided within two hours to prevent an acute admission", although how many areas have been able to offer this, and how many did so has not been revealed.

Conflicting assumptions

The 'discharge to assess' policy is based on the assumption that 65 pre cent of people will require no further care, and the other 35 per cent will require an ongoing package of care, although these numbers to not correspond with the 'pathways' analysis elsewhere in the document.

That analysis states (with no supporting evidence) that 50 per cent of people can simply be discharged home from hospital, with relatives or neighbours taking the strain and no further support from NHS or social care, while 45 per cent will need some support from health and/or social care to recover at home. Four per cent will need rehabilitation of short-term care in a 24-hour bedbased setting and just 1 per cent will need ongoing 24-hour nursing care.

For the 5 per cent of patients aged over 65 with needs too great to be returned to their own homes, "rehabilitation/short term care in a 24-hour bedded care facility will be arranged through the case manager. For people being discharged to a care home bed (short term or permanently) for the first time, this provision will be provided in a care home, at rates which have been agreed locally by the health and care system and will be free to the individual for up to six weeks".

Covid complications

However there are complications over covid-19 screening. The guidance states, "DHSC/Public Health England policy is that people being discharged from hospital to care homes are tested for covid-19 in a timely manner ahead of being discharged... Where a test result is still awaited, the person will be discharged if the care home states it is able to safely isolate the patient.

"If this is not possible then alternative accommodation and care… needs to be provided by the local authority, funded by the discharge funding."

It's not at all clear what "alternative accommodation" might be available or appropriate for patients who might potentially arrive with covid-19, and are also likely to require complex care – or how local authorities whose budgets and staffing for social care have been cut to the bone over the past ten years are expected to be able to spring into instant action and procure sufficient suitable alternatives on the immensely tight timetable set by NHS England (NHSE).

The expectation is that a "lead professional or multidisciplinary team… suitable for the level of care and support needs" will visit people at home on the day of discharge or the day after "to co-ordinate what support is needed in the home environment". It's not clear what options, if any, there are for patients and their families if this does not occur.

However what is clear is that any apparent generosity in the system and provision of ongoing care and support with no charge to the patient comes to an abrupt halt after six weeks, when the central support ceases and local health and care systems are left to their own devices.

The guidance continues, "Whatever arrangements are agreed, costs from week seven cannot be charged to the discharge support fund and must be met from existing budgets. Clinical Commissioning Groups (CCGs) and local authorities should agree an approach to funding of care from the seventh week."

"Around the country staff in community health and social care will be grappling now with the fall-out from these policy statements, without the necessary means to cope"

The discharge policy expects that an assessment for ongoing health and care needs takes place within six weeks of discharge, and that a decision will have been made by this date about how this care will be funded.

However it seems clear from NHSE's 31 July Phase 3 letter that this has not been the case with many of those patients discharged from hospital between 19 March to 31 August this year, who now form a hefty backlog of cases to be urgently assessed by hard-pressed local teams. In many areas the capacity to assess on the scale required is just not available.

Left to carry the can

The policy is clear on one thing: from six weeks after discharge from hospital the local NHS and social services are left to carry the can: "CCGs will not be able to draw down funding from the discharge support arrangements after the end of the sixth week to fund any care package beyond this date.

"On the rare occasion that a decision is not reached within this time-frame, the parties paying for the care should continue to do so until the relevant ongoing care assessments are complete. Whatever arrangements are agreed, costs from week seven cannot be charged to the discharge support fund and must be met from existing budgets. CCGs and local authorities should agree an approach to funding of care from the seventh week."

Around the country staff in community health and social care will be grappling now with the fall-out from these policy statements, without the necessary means to cope. The social care funding gap remains unresolved, as do the financial problems of hundreds of privately run care homes. The buck-passing guidance may have been published, but the implementation is far from a done deal.

John Lister

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Impossible demands: to step-up and redesign a raft of services

Plans for restarting urgent and elective NHS services, announced in a 13-page circular from NHS England (NHSE) to health service chief executives and accountable officers on 31 July, depend partly upon the rapid roll-out of a new network of 150 'community diagnostic hubs' which, according to online news site HSJ, have not yet secured funding, and for which there are as yet no local plans, or staffing so far in place *(see page 3 for more details – Ed)*.

The plans are part of a complex volley of proposals and instructions fired off by NHSE, with impossibly short deadlines for implementation. The disconnect between the voluminous top-down instructions and requirements on local trusts and commissioners on the one hand, and the availability of the resources to make them possible on the other, has seldom been more stark.

But the creation of community diagnostic hubs is only one of many unanswered questions to arise from NHSE's letter, and from the subsequent 46-page guidance document published on 7 August and a new hospital discharge 'policy and operating model' appearing two weeks later.

MRI procedures: back to normal levels by end of October?

Hospital care

The NHSE letter called on health bosses to re-establish and redesign services to deliver through their local NHS capacity the following:
– at least 80 per cent of pre-covid activity for both overnight electives and outpatient/daycase procedures in September, and 90 per cent in October
– "very swiftly" returning to at least 90 per cent of pre-covid levels of MRI/CT and endoscopy procedures, and 100 per cent by October

Whether such ambitious targets can be achieved so quickly, given post-covid restrictions, continued staff shortages (with some key staff having been reassigned), and the complexity of managing (and staffing) capacity commissioned in private hospitals on separate sites, isn't considered by NHSE. It just sent out the orders.

"The disconnect between the top-down instructions and requirements, and the availability of resources to make them possible, has seldom been more stark "

Another seemingly irrational instruction issued on 31 July was to reach 100 per cent of last year's activity for first outpatient attendances and follow-ups (face-to-face or virtually) from September on.

The wisdom and logic of piling up new elective referrals through the rapid rebuilding of outpatient activity while trusts are still struggling with the backlog of urgent surgery and patients who have already waited far longer than target times for treatment is not explained.

Primary care

While the proposals for acute hospital care are vague, there is even less detail in the sections on primary care. Dentists, who have been especially hard hit during the lockdown and face extremely onerous additional requirements for post-covid hygiene, are simply given an assurance of future support.

GPs are given no promises, but simply instructed to keep on doing more and "make rapid progress... through specific catch-up initiatives and additional capacity".

Community care

A huge question mark also hangs over the future resources and staffing of community health services. NHSE again offers no real steer on how its proposals can be delivered in practice:

"Community health services crisis responsiveness should be enhanced in line with the goals set out in the Long Term Plan," NHSE helpfully suggests, "and should continue to support pa-

tients who have recovered from the acute phase of covid but need ongoing rehabilitation and other community health services."

Continuing care

For community health and Clinical Commissioning Groups (CCGs) there is an additional unfunded nightmare, arising from NHSE's instruction that hospitals "must" discharge patients prior to their needs being assessed. This has been backed with temporary funding for support packages of up to six weeks only to keep patients out of hospital.

This means there are many patients who should already have been moved on, although there are no additional resources to support those who need continued support or long-term care.

The NHSE letter further cracks the whip demanding rapid action to catch up, saying "CCGs must resume continuing healthcare assessments from September and work with local authorities using the trusted assessor model. Any patients discharged from hospital between 19 March and 31 August, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements."

The letter makes no assessment of how many patients fall into this category, and no suggestion of where the extra staff should come from to conduct the additional assessments, where patients needing ongoing care should be cared for, by whom or at whose expense.

Displacement activity

The process of accelerated discharge that probably seemed such a bright idea to free up hospital beds is now likely to turn into an ongoing crisis six weeks after discharge, with large numbers of patients still not assessed, or left stranded with no facilities nearby capable of delivering the care they are assessed to require.

The NHSE letter's evasions and vague assurances continue on mental health and learning disability services, and on preparation for winter alongside the continued covid pandemic – with a promise that,"The Department of Health & Social Care will shortly be releasing agreed A&E capital to help offset physical constraints associated with social distancing requirements."

"The wisdom and logic of piling up new elective referrals through the rapid rebuilding of outpatient activity while trusts are still struggling... is not explained"

Elective surgery: doubt over when it will return

There are sections on workforce (ignoring the embarrassing fact that far from increasing GP numbers by the promised 6,000, the latest figures show numbers of fully qualified GPs fell by 651 in the past year), and even more vague suggestions on health inequalities and prevention.

Integrated care

As might be expected, NHSE is unwilling to let a good crisis go to waste, so the letter goes on to press for the more rapid imposition of "integrated care systems (ICS)", mergers of CCGs, and new measures to eliminate even the pretense of public consultation. All ICSs and Sustainability and Transformation Partnerships (STP) "are required to draw up a 'development plan' to "embed and accelerate this joint working".

And another thing...

However, this is not the only plan that senior management must work on at once in order to comply with the NHSE letter. Three further plans also need to be drawn up at a rapid pace, with tight timescales making it impossible for there to be any local consultation or genuine involvement in producing them:

– a plan to streamline commissioning through a single ICS/STP approach, typically leading to a single CCG

– a plan for developing and implementing a full 'shared care record', allowing the safe flow of patient data between care settings, and the aggregation of data for population health

– a draft summary plan "by 1 September using the templates issued and covering the key actions set out in this letter, with final plans due by 21 September"

In addition, applications also need to be drawn up in the next two weeks in areas where CCGs have not yet merged into larger bodies with even less local accountability. Once again only the most token consultation will be possible in the timescale on proposals (to be submitted later this month) that in some areas have already been specifically rejected by local GPs or as a result of local opposition.

John Lister

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Trust opts to ditch in-house catering

Unions representing 70 NHS employees working in catering, logistics and patient services at Hinchingbrooke Hospital are in dispute with North West Anglia NHS Foundation Trust, which has put these services out to private tender.

The move follows the merger of Peterborough & Stamford Hospitals Trust with Hinchingbrooke Hospital, where despite a period under management by Circle, key services remained in-house.

Unison and Unite claim the move to outsource Hinchingbrooke's award-winning catering department puts the trusts at odds with other top-performing hospitals and with the stated views of health secretary Matt Hancock.

The trust wants to combine Hinchingbrooke's catering, cleaning, portering and other support staff with around 100 facilities staff already outsourced to three different firms at its other hospital sites in Peterborough and Stamford, and award a single private contract.

Fresh food is better for patients, says Hancock

Putting standards at risk

However the attack on the hospital's catering department, which freshly cooks meals for patients and staff from locally sourced ingredients, and the plan to hand the contract to a private company reliant on bulk-processed cook-chill food, is sharply at odds with a drive announced last year by Hancock towards bringing hospital catering back in-house to improve standards.

In the aftermath of the tragic deaths from listeria last summer of NHS hospital patients across England after eating food from a private supplier, Hancock said, "Dozens of hospital trusts have brought their catering in-house and found that they get better quality food that is more likely to be locally produced and is better value for money."

But while Hancock has gone on to reaffirm his preference for hospitals to serve freshly cooked food prepared on site, and in January in a blaze of publicity opened a brand new £3m hospital facility to cook fresh meals in Chichester's St Richard's Hospital, NW Anglia bosses are intent upon eliminating quality catering at the trust.

"No business case has been produced to show what management might hope to achieve from this initiative"

Outsource at any cost

The plan is a triumph of ideology over evidence, since any claims that privatisation might lower costs or increase efficiency are undermined by the latest official NHS figures that show tthe cost per patient meal is significantly higher for supplying bulk-processed food from the privately-run re-heating facilities in Peterborough Hospital (averaging £5.33 per meal) than from the professionally-run in-house kitchens preparing fresh food in Hinchingbrooke (averaging £3.64).

The logic behind the decision to put catering and logistics services out for tender, when the food delivered to patients in Hinchingbrooke is 46 per cent cheaper as well as superior in quality, is unclear.

The unions point out that no business case has been produced to show what the management might hope to achieve from this initiative, and despite misleading claims in the local press by the trust's chief operating officer, there has been minimal consultation with the unions – and no prior engagement with the staff whose jobs, and terms and conditions of employment are at risk.

Ignoring the evidence

It is remarkable that its HR department was unable to supply any answers to questions about the key performance indicators (KPIs) applying to the existing outsourced contracts, or indeed those for the new contract that companies are now being invited to tender for.

Clearly, for the estates department which is leading this ignominious charge towards outsourcing, the answer is 'privatisation' whatever the question and regardless of the evidence.

Catering staff at Hinchingbrooke have written to the health secretary asking him to intervene to prevent a downgrade of services, and the unions have also written to all four local MPs as well as local councillors to highlight their concerns.

The unions have also launched a petition calling for all North West Anglia NHS staff to be employed in house, not by private profiteers.

John Lister