The lowdown

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

Where is all the money going?

IT APPEARS nothing succeeds more than failure. Serco, one of the two corporations with key contracts to deliver the shambolic 'test and trace' system, has picked up another extension to its contract of up to £400m amid devastating new figures on how poorly the service is performing. The failures continue despite employing an army of management consultants on daily rates of up to £7,000, with just 15 per cent of test results returned within 24 hours and only 46 per cent of close contacts reached.

And while under-funded NHS trusts face the deadly combination of a second uncontrolled wave of covid-19 infections with winter pressures, together with financial penalties if they fail to reach performance targets set by NHS England bureaucrats, failing Serco has proudly announced a big increase in profits above its projections for the year, promising that the extra cash will be shared out with investors.

Health minister Helen Whately has confessed that the contracts for the test and trace service explicitly contained no penalty clauses to deter Serco and call centre operator Sitel from failing to deliver, claiming – falsely – that "contractual penalties are often unenforceable under English law".

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But even this level of ineptitude in ensuring the public sector secures value for money in its huge spending on the response to covid-19 is minuscule in comparison to the colossal sums that are unaccounted for in the whole test and trace system where – according to Tussell, which monitors contracts – the government can only account for a third of the £12bn budget so far.

There are real questions to answer on the actual costs: £12bn is equivalent to £179 per head of the UK population of 67m. How could this much have been spent?

Yet more costs

To the cost of contracts of up to £400m for Serco and almost the same for Sitel must be added costs of setting up and running the parallel part-private Lighthouse laboratories and NHS labs, and of course procurement of the testing kits themselves. We know that there have been false starts on this, with £20m wasted on one consignment of testing kits from China, but we don't know how much the basic tests are costing as ministers hand out fresh preliminary contracts for a £100 bn 'moonshot' project supposedly to deliver 10m tests a day by early 2021.

We also know that hundreds of millions, and quite possibly billions from the £15bn allocated to purchase PPE have been misspent on contracts awarded without due process to small start-up companies and firms with no relevant expertise, some linked to the Conservative Party or Tory donors. The Good Law Project working with EveryDoctor is mounting a legal challenge to the contracts awarded to three of the biggest beneficiaries – companies specialising in pest control, a confectionery wholesaler and an opaque private fund owned through a tax haven.

Value for the public purse?

In this issue of The Lowdown we also question the value for money of NHS England's secretive deal to secure use of private hospital beds, equipment and staff, as NHS bosses issue a new framework contract for up to £10bn over four years.

With the vast majority of the £31.9bn covid-19 spending on health services flowing not to the NHS but into various private sector companies, and the National Audit Office review of covid-19 spending not due until the end of the year, we need to demand our politicians and NHS leaders at national and local level reveal where all this money is going, and what we get for it.

"Serco has proudly announced a big increase in profits above its projections for the year"

Health workers, already feeling the strain of another pandemic surge as winter sets in, need and deserve answers – with action as demanded by the Labour Party to remove incompetent management and contractors, and prosecution of any proven corruption.

John Lister

Serco staff drafted into clinical tracing, but are they qualified?

Tier 2 contact tracers have previously needed clinical backgrounds

LEAKED EMAILS and texts seen by The Lowdown and other news sites have revealed moves to bolster the clinical tier of the government's contact-tracing programme with untrained staff from outsourcing giant Serco and call centre outfit Sitel.

Shortly before the prime minister belatedly admitted last week to serious failings in the contact-tracing programme, and as cases of covid-19 continued to surge across the north of England, clinical caseworkers already working in 'tier 2' – recruited by the Department of Health & Social Care-owned agency NHS Professionals (NHSP) – were told of the moves in an email and a series of mobile phone texts.

The email, from NHSP and dated 20 October, spoke of changes being "introduced… to provide the additional capacity to meet this surge", and told existing staff that a number of "experienced agents from Serco and Sitel" would soon be assisting them, albeit focusing primarily on "gathering information".

Not registered? No problem

Follow-up reports in the Independent and on Sky News found damning evidence of how little clinical experience these 'agents' might actually possess. This suggests that NHSP may have expediently ditched its previous insistence that tier 2 staff should be "registered with an appropriate health- or science-related professional body and are working, or have worked, at a [Clinical] Band 6 level".

Despite this relaxation – and despite 'call to action' texts to existing tier 2 staff in early October alerting them to an "urgent requirement to fill additional shifts", upping the number of hours that staff could work each week from 42 to 60 – NHSP has also now halted direct recruitment of clinical contact caseworkers, telling potential applicants online that it is "not progressing any further applications at this stage".

Whether the move to bring in staff from Serco and Sitel is about boosting capacity or boosting private sector participation is unclear, but in its 20 October email NHSP seemed unconcerned about the lack of clinical expertise among the latest tier 2 recruits. It merely advised recipients that "new starters" from Serco and Sitel "will require additional support as they transition from their initial training into experienced caseworkers".

That support hasn't always been available to contact tracers. Online news site openDemocracy last month revealed that customer service staff from holiday company Hays Travel, working as subcontractors on Serco's test and trace operation, complained of insufficient training being provided. One said, "We are not medically trained and I believe members of the public believed they were ringing medically trained people."

Safeguarding issues

When we spoke to one person working in the tier 2 group – who asked not to be named – about the move to bring Serco and Sitel employees on board, they were clearly disturbed by the prospect.

"I thought tier 2 staff were the 'clinical' support level, drawn from professions which are regulated by bodies like the Health & Care Professions Council, Social Work England or the Nursing & Midwifery Council.

"Opening the tier to Serco and Sitel staff brings into question the value the government sees in having a 'clinical' input over the need to process the volume of cases. [These] employees may be experienced call centre staff, but can they identify a safeguarding situation?"

However, as well as the clinical and safety concerns raised by this latest policy decision from the Department of Health & Social Care, it's helpful to consider its wider political implications.

Three years ago the department abandoned its plan to sell off NHSP. It was reported at the time that one of the leading bidders for the company was Serco, whose chief executive said earlier this year, in relation to its contact tracing contract, "If it succeeds… it will go a long way in cementing the position of the private sector companies in the public sector supply chain."

Martin Shelley

Scientists unite to reject right-wing call for 'herd immunity'

ALMOST 5,000 scientists, researchers and healthcare professionals have now signed the John Snow Memorandum – which is not a note to the well-known presenter of Channel 4 News, but a challenge to libertarian and right-wing extremist attempts to undermine efforts to restrict the spread of the coronavirus.

John Snow was a 19th-century pioneer of what later became the public health movement: he famously tracked back from infected patients dying of cholera in south-east London, to trace its source in the polluted water being drunk from a single pump in Broad Street. The removal of the pump handle brought an end to the outbreak.

The John Snow memorandum is calling for similarly bold and scientifically-based action by governments in Britain and internationally to clamp down on the transmission of the virus and simultaneously step up the performance of the lamentable centralised test and trace system.

"We cannot lock entire sectors of society away because others want to live their lives 'as normal'."

Sir Robert Lechler

Rebutting bad science

The trigger for this concerted effort by concerned scientists to uphold the principles of public health medicine was the publication in the US in early October of the so-called 'Great Barrington Declaration', as part of a fresh and more vigorous international offensive by right-wing media pundits and politicians arguing against any lockdown measures to contain the virus, and for the virus to be allowed to infect a large percentage of the population, reviving the discredited notion of "herd immunity".

The declaration was backed and given a slick media launch and champagne reception in New England by the American Institute for Economic Research (AIER), a lavishly-funded neoliberal think tank, not entirely dissimilar to the right-wing Institute of Economic Affairs in the this country.

Sir Robert Lechler

A Guardian rebuttal of this 'bad science' has noted that the AIER "has a history of funding controversial research – such as a study extolling the benefits of sweatshops supplying multinationals for those employed in them – while its statements on climate change largely downplay the threats of the environmental crisis".

Lack of peer review

Now the AIER website, in another article headed 'Government Policies Have Worsened the Coronavirus Crisis', is just as eager to downplay the significance of 1.1m covid-19 deaths worldwide. It states, "According to the World Health Organization (WHO), as of the middle of October 2020, there were over 39m global confirmed cases of the coronavirus, with almost 1.1m deaths attributed to it. It is worth keeping in mind that the world population is estimated at over 7.8bn people. This means that, as of now, 0.005 per cent of the world's population have caught the virus and 0.0000141 percent of all the people on the planet have died due to the virus."

Its opponents point out that the views set out in the Great Barrington Declaration are not based on evidence, and the scientists feted at the launch of the document have not had these views published in any peer-reviewed scientific journals.

The declaration claimed to have been signed by 27,000 people, although few of these had any relevant scientific or health credentials, and many of these signatures have been shown to be bogus after a campaign identified a weakness in vetting added names.

'Simply unethical'

The notion of relying on some eventual possible development of 'herd immunity' to the virus rather than seeking to contain it until a proven vaccine can protect the population, which could mean 2m or more deaths from covid-19 in the US to reach even a 65 per cent threshhold, has been rejected as "unethical" by the head of the WHO Dr Tedros Adhanom Ghebreyesus. He said:

"Herd immunity is achieved by protecting people from a virus, not by exposing them to it. Never in the history of public health has herd immunity

been used as a strategy for responding to an outbreak, let alone a pandemic. …

"Allowing a dangerous virus that we don't fully understand to run free is simply unethical. It's not an option."

'A dangerous fallacy'

In Britain, the declaration has also been explicitly rejected by the President of the Academy of Medical Royal Colleges, Professor Sir Robert Lechler:

"We cannot lock entire sectors of society away because others want to live their lives 'as normal'. Neither should we expect younger or healthier people in the population to take a hit for herd immunity, especially when there is so much we are still to discover about the long term effects of covid-19. We should not be making plans or decisions on how to control its spread behind closed doors in wood-panelled rooms. We must engage with people in the communities most affected to make sure that no decision about them is taken without their input."

The John Snow Memorandum, also published by The Lancet, describes the herd immunity approach as "a dangerous fallacy unsupported by medical evidence", and warns that:

"Such a strategy would not end the covid-19 pandemic but result in recurrent epidemics, as was the case with numerous infectious diseases before the advent of vaccination. It would also place an unacceptable burden on the economy and healthcare workers, many of whom have died from covid-19 or experienced trauma as a result of having to practise disaster medicine."

"Opponents point out that the views set out in the Great Barrington Declaration are not based on evidence"

Instead the memorandum points out that alternative models have been proven to work:

"Japan, Vietnam and New Zealand, to name a few countries, have shown that robust public health responses can control transmission, allowing life to return to near-normal, and there are many such success stories. The evidence is very clear: controlling community spread of covid-19 is the best way to protect our societies and economies until safe and effective vaccines and therapeutics arrive within the coming months."

Putting all this in perspective, it's worth noting that in Trump's US, a vivid example demonstrates the value of preventive measures against the virus. The lifting of 'stay at home' regulations in the Republican-led state of Arizona in mid-May led to a rapid 151 per cent increase in covid-19 cases two weeks later.

Meanwhile, the local imposition of requirements to wear masks from mid-June, accompanied by the closure of bars, gyms, theatres and other centres, brought an equally rapid 75 per cent reduction in new cases over the following three weeks, even though there is still no state-wide mandate to wear masks.

John Lister

NHS staffing: is it getting safer?

BEFORE THE pandemic the NHS had a staffing crisis which was making the service less safe. Is the current guidance for staffing levels being followed?

Prior to the challenge of covid-19, services were already regularly being understaffed which meant a fall in the quality of care and an increase in serious events. At the end of last year nine out of ten NHS bosses said that the staffing crisis was endangering patients.

It is a longstanding problem. The 2018 publication of staffing guidance by the Royal College of Physicians was prompted by concern that levels of medical staffing had fallen dangerously low.

The Royal College of Nursing's (RCN) 2019 report 'Standing up for Patient and Public Safety' noted that if there is understaffing, nursing staff are more likely to report that care is compromised, of poor quality, or left undone.

In April last year, the study 'Implementation, Impact and Costs of Policies for Safe Staffing in Acute NHS Trusts', published by the University of Southampton, warned that the new workforce guidelines had not led to significant improvements on the hospital wards.

Data from the 2019 Heads of Midwifery (HoMs) survey showed that staffing levels often do not comply with the 'birthrate plus' (BR+) guidance for the minimum staffing levels a maternity service needs.

Almost half of HoMs (48 per cent) said that they did not have the funding for the right numbers of staff to meet the demands on services. This level was up from 32 per cent in 2018.

What is safe staffing in healthcare?

Safe staffing is a level of staff on a ward or within a service, such as district nursing or health visiting, that means that the highest quality of care is maintained for both the patient and the members of staff.

In 1967 a 'gold standard' ratio of one registered nurse to each

patient was set and this continued to be the ideal for decades. However, over more recent years, it became clear that safe staffing is often not as simple as the number of staff. It is also concerned with having the correct mix of staff, and having staff with certain levels of training within a team.

How are staff levels determined?

Staff levels are determined by both government and professional bodies.

In 2018, NHS Improvement (NHSI) produced guidance on safe staffing to guide trusts and health service providers covering maternity, urgent and A&E, neonatal and young people's service, learning disability services, district nursing, mental health services and adult inpatients in acute care.

The RCN publishes its own guidance on staffing levels in various settings, including general wards and older people's wards.

The Paediatric Intensive Care Society has published the Standards for the Care of Critically Ill Children for workforce planning around critical care.

The Royal College of Psychiatrists has developed quality standards covering minimum staffing levels and skill mixes for psychiatry liaison teams.

In maternity the accepted model for determining what minimum staffing levels a maternity service needs is called 'birthrate plus' (BR+), published by the Royal College of Midwives.

In resuscitation areas in A&E, guidance published by the Faculty of Intensive Care Medicine and the Intensive Care Society in 2015 recommends 1:1 or 1:2 nurse-to-patient ratios.

In 2018, the Royal College of Physicians produced the report 'Guidance on safe medical staffing' aimed at helping planners answer the question: "How many doctors or their alternatives, with what capabilities, do we need to provide safe, timely and effective care for patients with medical problems?"

How did the idea become more prevalent?

Health unions such as Unison and the RCN have run campaigns about the impact of understaffing over many years to raise the issue, but in 2014 a body of evidence emerged through large scale EU-funded studies concluding that death rate rose as nurses had to deal with more patients.

In 2013 four reports pushed the idea that minimum safe staffing levels lead to the best quality of care for a patient. The most famous of these reports was the Francis Inquiry that examined failures in care in the Mid-Staffordshire NHS Foundation Trust. The inquiry recommended that the National Institute for Health and Care Excellence (NICE) should draw up minimum safe staffing levels, including nurse levels, policed by the Care Quality Commission.

What safe staffing plans were developed?

NICE published guidance in 2015 that included a 1:8 nurse-to-patient ratio for general wards after research showed that it was the level that, if exceeded, harm started to occur to patients.

NICE continued to work on guidance for maternity and A&E, but before it could publish any more guidance, the organisation was asked to stop all its work on safe staffing. The work was moved to NHSI, but by June 2016 it was clear that further guidance on safe staffing levels containing strict guidelines and patient to staff ratios was unlikely.

What happened next?

NHSI continued to work on guidance, but using different methodology from NICE. Eventually, in 2018, it produced its guidance on the level of safe staffing. It covered maternity, urgent and A&E, neonatal and young people's service, learning disability services, district nursing, mental health services, and adult inpatients in acute care.

But none of these guidance documents contains a staff to patient ratio.

Differences between the home nations?

It was a different story in Scotland and Wales, where legislation on safe staffing was made law.

In 2019, the Scottish government passed the groundbreaking Health and Care (Staffing) (Scotland) Act. Almost three years in the making, the act is the first in the UK to set out requirements for safe staffing across both health and care services, and most clinical professions.

In 2018, the Nurse Staffing Levels (Wales) Act came into force. This contained high-level recommendations for the Welsh government and health boards looking at effective practice, the sustainability of the workforce and progress needed.

What needs to happen now?

A growing body of healthcare professionals, including the RCN and Unison, believe that the only way to ensure that safe staffing levels are maintained is to introduce legislation, as has been done in Wales and Scotland.

However, in England neither the NHS Long Term Plan published in 2019 or the subsequent NHS People's plan called for legislation around workforce levels.

The RCN is calling for a legal framework of accountability for workforce planning and supply which covers all publicly funded health and care services. This includes social care and public health. This will also include the independent sector when they are providing publicly funded health and care services.

Sylvia Davidson

South East London CCG pathology outsourcing set to undermine local NHS trust

REGULAR READERS of The Lowdown may remember that the SE London Integrated Care System (ICS) – 'Our Healthier South East London' or OHSEL – has been overseeing the drawing up of a huge pathology network contract for south-east London. The estimated value is a staggering £2.25bn over 15 years (with a five-year extension option). South East London Clinical Commissioning Group (SELCCG) has now given the green light to the private company Synlab.

Lewisham & Greenwich NHS Trust (LGT) chose to opt out of the contracting process, deterred by the size of the contract and the fact that local NHS partners appeared to favour a partnership with the private sector.

LGT is now working with the Barts and the Homerton NHS trusts to provide a wholly NHS pathology network, aiming to maintain the link between the pathology service and their respective communities in north-east and south-east London, and NHS England and NHS Improvement are not obstructing this path.

Part of LGT's work has been 'direct access' pathology services for GPs, mental health and community services in the three boroughs of Lewisham, Greenwich and Bexley, over 45 per cent of its pathology income. This service has been satisfactorily delivered for years, but after next April will come from Synlab, an international private provider with no proven record of good service delivery in south-east London.

Previous assurances (minuted at a Lewisham Council 'healthier communities select committee' meeting in October 2019) that direct access pathology for borough health services would be subject to local borough-based commissioning have been ignored.

Back-room deals?

So this major commissioning decision for the OHSEL ICS, taken by the recently merged SELCCG, has flouted previous commitments and in one swipe takes services worth £12.1m from Lewisham and Greenwich NHS Trust.

In a related twist that smells of back-room dealing, the Kings College Hospital and Guys and St Thomas' (GSTT) NHS foundation trusts bought out Serco's share in their joint partnership company Viapath, which has been providing pathology services for those trusts and other contracts. Kings and GSTT now are described as being in a joint partnership with Synlab to provide the pathology network contract – including the six-borough south-east London direct access pathology service.

Many local campaigners will feel that between the ICS, the CCG and the two foundation trusts, Lewisham & Greenwich NHS Trust's pathology services have been stabbed in the back.

The trust will lose £12.1m income (at 2018/19 prices). Consequences for their pathology department in terms of loss of staff and service capacity will inevitably follow, and undermine the ability to demonstrate 'value for money' for future years, 2022/23 onwards. SELCCG denies any risk or impact on the south-east London health system.

No turning back

The CCG claims that the award for direct access pathology is only for 2021/22, but it is inconceivable that services will be re-provided by the new private contract only to be returned to the NHS so shortly after.

And Synlab certainly seems to be in it for the longer term, with its CEO stating:

"I am delighted that Synlab has been chosen to transform and deliver pathology services in south-east London" and predicted that "The collaboration will bring a raft of improvements for patients, with urgent and routine tests turned around more quickly." He also promised the NHS "substantial cost savings."

This all remains to be seen, but if this is the kind of undemocratic decision that can emerge through the new NHS structure of ICSs and merged CCGs, then other massive outsourcing deals over 10-15 years could surely follow. Campaigners and NHS trusts should beware.

Tony O'Sullivan

People's lives in Kent are in the hands of Matt Hancock

IT IS NOW his decision whether to allow or not allow local NHS bosses to close half of the county's stroke units, including one at Margate hospital which serves Thanet, one of the poorest parts of south-east England. Many thousands of people, it is feared, will be left too far from the emergency treatment they may need.

Until covid-19 struck, there were six acute stroke units in Kent, all located at district general hospitals. In 2018 plans were made public to shut half of them, leaving just three acute stroke units for the whole of Kent and Medway — a population of 2.2m.

A legally required public consultation followed. During the consultation, the campaign group Save Our NHS in Kent (SONIK, a grassroots community campaign) exposed the stroke unit plan's considerable flaws, and there was a generally hostile public response. But despite huge protests, the plans were passed in early 2019.

Letter of the law

But the fight went on. Medway Council voted to refer back the plans to the health secretary Matt Hancock, and a request for a judicial review was mounted by three parties including SONIK.

In early 2020 the news came through that the judicial review had failed. The review, campaigners discovered, was all about the letter of the law, and not the spirit.

The NHS execs didn't have to disprove potential dangers and drawbacks – merely stating that they had "considered" them was enough, according to the law.

So hopes now hinge on Hancock. He will look at the recommendations of an 'independent panel' but as this is stuffed with business-minded managers and the decision was made by a team chaired by a Conservative Party peer, campaigners have little hope they will do anything but recommend that the plans go ahead.

An election issue

But what about Hancock himself? The expectation is that he will approve the plans, because they come from the government, and are firmly in line with the Conservative Party's well-established approach to NHS services: cutting costs through centralising services – regardless of the impact on patients – and diluting the public impact of the closures by appearing to devolve decision-making locally.

So why is Hancock delaying his decision? One reason may be his fear of bad publicity and how this may affect next year's county council elections. But a larger issue is how any unpopular closure might be seen to contradict the recent government line that the Conservative Party is a generous benefactor to a much-loved NHS.

Consultation? What consultation?

Whatever the outcome, SONIK's struggle to prevent the decimation of Kent's stroke services has at least exposed the bogus nature of the public consultation process the NHS execs undertook.

Campaigners' questions have been avoided, answered only after long delays – or then only partially answered.

An ongoing pretence of openness and consultation has been maintained – but it has been only a pretence.

This was underlined by an incident in September when Rachel Jones, director of the stroke review, declared publicly that she proposed to work with SONIK and east Kent residents on a "daily" basis, to reassure people about the delivery of stroke services in the locality.

SONIK quickly contacted Ms Jones and invited her to a meeting. Absolutely no response was received, and crucial questions directed to Jones have all been sent to the 'black hole' of Freedom of Information requests. Rachel Jones was playing to the gallery: her promise was only for show.

Carly Jeffrey

SONIK's petition: https://bit.ly/31f7m9w

Closed eyes to covid reality: Leicester health chiefs push through flawed plan

ANOTHER ONE of the six actual planned new hospitals from Boris Johnson's 'fake 40' promised last summer seems set to be rushed through with minimal scrutiny or consultation, and do far more harm than good to local services and capacity.

As local health chiefs and too many local politicians in Leicester, Leicestershire and Rutland (LLR) apparently opt to turn blind eye to the gaps and weaknesses in the plans, and grasp the promised £450m rather than risk delays, local campaigners are faced with the latest of a succession of half-baked plans that could leave the area desperately short of resources for decades to come.

In 2014 a 'strategic outline case', bizarrely titled Better Care Together, proposed shutting one of University Hospitals Leicester's (UHL) three hospitals, axing 427 beds, with Leicestershire Partnership Trust expected to take on the care of 250 "beds worth of activity" without any additional bed capacity.

Two years later health bosses in LLR drew up a hopelessly impractical 'sustainability and transformation plan' (STP), again cutting from three down to two acute hospitals and closing 243 acute beds at Leicester General to focus services at Glenfield and Leicester Royal Infirmary, at a cost of £280m. The STP also proposed to axe 1,500 hospital jobs, recruit 234 extra primary care staff, and cut 38 beds from two community hospitals.

Inadequate plan

The ill-founded hopes of closing 13 per cent of available beds in the patch soon perished in the winter pressures that followed, but local NHS leaders have clearly learned nothing, and remain

stubbornly resistant to planning seriously for the future. The latest plan would also leave the area desperately short of beds, and community and primary care services saddled with extra, unfunded, demand.

UHL and local commissioners have now plunged into a consultation on a gigantic but unconvincing 'pre-consultation business case' (PCBC), which is due to end on 21 December, despite concerns raised by local campaigners about the restrictions that will limit the normal processes of a full public consultation during the covid-19 pandemic.

But perhaps more worrying is that the PCBC, drafted in obsessive secrecy, was finalised last year and eventually signed off in January – just before the pandemic struck in full force. All of the public engagement it refers to was years ago, in a different time completely.

And rather than pause the already delayed process a little longer to allow a proper evaluation of the longer-term implications of the pandemic for the design and capacity of hospital services, the decision was taken in September to rush ahead with a 12-week consultation on a £450m scheme that will irreversibly change local hospital services by selling off land and buildings. Only a flimsy four-page preface to the PCBC makes even passing reference to covid-19.

Numbers game

It appears from the bland words of the PCBC (on p11) that the management has changed its tune on bed numbers, and is now advocating an increase: "A bed model has been produced to support the reconfiguration plans and the proposal is to increase the current level of beds from 2,033 to 2,333. Therefore there are no proposals to decrease bed numbers."

However a closer look at the proposals reveals that the 300 additional beds are largely imaginary, and there is no plan to build any additional beds at all. The diagram (on pp6 and 254) shows that the equivalent of 161 beds is supposed to be covered by "planned efficiency", 41 are to come from converting "non-clinical space", 28 involve simply re-labelling 28 existing rehabilitation beds, and the remaining 70 beds in "additional contingency wards" are not funded and would only be subsequently built if required (not clear where). The PCBC states on p7, "The Trust will, if necessary, address this in later years through CRL funding for what equates to 2.5 wards."

All of the PCBC's hyper-optimistic assumptions were made pre-pandemic, and take no account of the new requirements for social distancing, reducing numbers of beds in ward spaces, diversion of staff to deal with peaks of infection impeding the smooth implementation of efficiency measures, or the emerging chronic problems and pressures on services of patients suffering 'long covid' in the aftermath of the virus.

A core assumption is that previous planning norms of aiming for 85 per cent occupancy of acute beds would be discarded, and a new 'normal' occupancy rate of 90 per cent – and 93 per cent for day case and elective care – adopted. This was a risky assumption prior to covid-19, but the pattern of bed use during 2020 gives a glimpse of the problems that require this element of the PCBC to be re-thought and revisited.

Neither the bed numbers nor the occupancy levels will be those assumed. The trust responded to a Freedom of Information Act request to give a bed count of 1,848 beds available overnight on 31 January 31 this year – comprising 1,678 general and acute beds and 170 maternity beds.

Future impact

However this is misleading. NHS England's winter 'sit rep' reports show that the trust reported just 1,592 core general and acute beds open on that day, bolstered by 91 temporary 'escalation beds', to give a total of 1,603.

Even this lower figure is an exaggeration of the actual capacity of UHL acute beds post-pandemic. UHL figures reported to NHS England's covid-19 daily situation report showed the trust had an average of just 1,086 acute beds occupied from April to the end of June, while Department of Health & Social Care statistics show an even lower average of 984 (67 per cent of the 1,454 general and acute beds available).

The covid-19 sit reps show that UHL bed occupancy rates increased to an average 1,275 in the next two months, but it's clear that the hospital has not been able to make full use of its full bed capacity – even in the less demanding summer period since covid-19 struck.

The impact of this will be felt in the growing delays in treatment for cancer, cardiac and all of the non-covid-19 conditions that previously made up the main caseload of the hospitals. No matter how shiny and new a £450m hospital may be, if the two sites wind up with insufficient capacity to treat the ongoing future numbers of covid-19 patients as well as handling routine care and emergencies, the new scheme will not properly equip LLR for the future.

This is not the only glaring flaw in the PCBC, which does not comply with Treasury Green Book guidance which calls for "do minimum" options to be considered. Its costings are based on outdated 2019 figures as other hospital projects escalate in cost.

It's clear that the plan is being railroaded through for political reasons, to grab the cash on offer whatever the consequences. Local people are likely to rue the day their leaders took such a short-sighted decision.

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