# The Pandemic & Privatisation

## Campaign resource pack for conference

## THURSDAY February 25 2021

- Privatisation – why it matters:
- Billions wasted on PPE and Track and trace fiasco
- Privatised staff as second class citizens – the impact on the NHS
- Lighthouse (and mega) Labs: bypassing the public sector
- The great consultancy boom from Covid to ICSs
- NHS cash to the rescue for private hospitals:
- Learning lessons past & present: developing popular arguments & accessible information

**CONFERENCE CALLED BY**
Health Campaigns Together, supported by UNISON, Unite, GMB, TUC, ***The Lowdown***, NHS Support Federation, Keep Our NHS Public, and Centre for Health in the Public Interest

HEALTH CAMPAIGNS TOGETHER #our NHS

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This campaign resource pack has been prepared for the conference: **The Pandemic and Privatisation**, to be held online on February 25 2021.

It has been compiled and researched by John Lister and Paul Evans of ***The Lowdown***, with grateful thanks to articles written and information supplied from We Own It, Pat McGee and David Rowland of Centre for Health in the Public Interest.

Every effort has been made to ensure that the articles are accurate, and many contain live hyperlinks to source information.

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February 23 2021

# Why does NHS privatisation matter?

## Key arguments in brief

- The NHS is open to all patients, whereas private companies will restrict access to protect profits and abandon NHS contracts when their profits fall, leaving the NHS to pick up the pieces.
- Public funds spent with private companies flow out of the NHS and lead to underinvestment in the NHS staff and equipment.
- Studies show that outsourcing is associated with lower quality care and poorer access and can be unsafe. And yet some companies are still contracted despite their poor track record.
- Staff terms and conditions are less protected, continuity of care is more difficult, and outsourcing offers the public care that is less accountable and poorer value.
- Outsourcing can help patients where NHS care is not available: but overall, the evidence shows that the NHS provides better value and fuller access to high-quality care.

**By Paul Evans**

## Why it matters now

Exhausted NHS staff are trying to respond to record waiting lists but are seriously impeded by a long-term crisis in staffing, that includes over 90,000 vacancies.

This is eyed by the struggling private health industry as a golden opportunity to revive its fortunes. A multi-billion 4-year deal with private hospitals is in the pipeline and could see a big surge in NHS patients treated in private units.

And of course, care must be found for all NHS patients, but if this deal and others like it divert sorely needed investment in the NHS, then the reliance on the privateers will grow and NHS capacity will remain far too low.

Important questions about the safety of post-operative care in private hospitals and the value of the contracts hang unresolved.

Meanwhile, ministers have by-passed NHS and public health facilities in favour of signing up commercial outfits to run the £23bn test and trace programme and are withholding information about a host of other covid deals signed with the private sector.

Investigations have already unearthed cronyism in the signing of deals and evidence that some of the companies chosen lack any relevant business experience.

Under the cover of the pandemic NHS privatisation is rising, along with damaging consequences.

## Privatisation compromises the NHS

Professor Stephen Hawking, lived with motor neurone disease for more than 50 years using the NHS throughout, and wrote in the final years of his life that the NHS is "the fairest way to deliver healthcare". The mission of the NHS is to deliver comprehensive care to all in our society, prioritizing those with the greatest clinical need. Private companies may claim to support these aims, but in practice the drive for profit places limits on the care they will offer. Fundamentally, the commercial strategy will always diverge from the aims of the NHS.

## Patient safety

The record of NHS outsourcing has been tarnished by a catalogue of instances of harmful cost-cutting and the delivery of substandard care.

Three examples:

**Cygnet,** a specialist mental health provider that operates more than 150 facilities across the UK, has been repeatedly criticised by the Care Quality Commission (CQC). In September 2020, an unannounced inspection of Cygnet Yew Trees, a facility for women with learning disabilities, found evidence of staff "abusing patients, acting inappropriately or delivering a poor standard of care".

A private hospital run by **BMI Healthcare** that treats up to 10,000 NHS patients a year, put their safety at risk according to a report by the health watchdog. The CQC rated Fawkham Manor hospital in Kent as "inadequate" – the worst possible ranking. Staff told the health watchdog that financial targets were prioritised over patient safety at the hospital, where NHS patients make up almost half the caseload.

**DMC Healthcare** had several contracts for GP surgeries in the Medway area. However, when the Care Quality Commission found serious concerns with the quality of healthcare. enforcement action was taken, and the company was removed from running five surgeries and suspended from three others.

Further examples of the failures of outsourced services are available here.

## Price competition lowers quality

For non-clinical services like cleaning and security, where price competition is allowed, commercial providers can win contracts by underbidding competitors, but to keep to the price, quality often suffers.


A 2019 study of 130 NHS trusts, looking into the impact of outsourced cleaning services concluded that "*private providers are cheaper but dirtier than their in-house counterparts.*" They found lower levels of cleanliness and worse health-care outcomes, which can be measured by the number of hospital-acquired infections.

A further international study has confirmed the relationship between the quality of cleaning services and the frequency of hospital-acquired infections, with the clear implication that outsourcing cleaning services can threaten patient safety and cost lives.

## Staff can be poorly treated

A string of recent disputes over terms and conditions reinforces the message that outsourced staff often get a worse deal than their NHS equivalents.

In Southampton staff working for Mitie Security Ltd went on strike last year over pay, sick pay and a lack of protective equipment, which they need to help deal with regular attacks from the public – often under the influence of drink or drugs.

In Doncaster, catering staff employed by French company Sodexo were told that NHS pay levels could not be matched. And in Wigan drug and alcohol workers were forced to strike after their employer Addaction refused to keep pace with NHS pay rates for equivalent jobs.

Porters, cleaners and security staff working for NHS trusts across the country have also been forced to fight and sometimes strike against their NHS employer's plans to transfer them over to "money-saving" subsidiary companies, moves which have been vigorously opposed by trade unions as unjust and privatisation by the back door.

### Covid contractors include:

- **Deloitte** to manage the logistics of national drive-in testing centres and super-labs.
- **Serco** to run the contact tracing programme.
- **Capita** to bring returning health workers on board in England.
- **DHL, Unipart, and Movianto** to procure, manage logistics of, and store PPE.

## Services less secure

As the use of the private sector expanded it became clear that companies were dropping out of contracts when profits fell.

In these circumstances, the NHS has stepped in, sometimes at short notice and at its own cost to keep the service going, but of course, the continuity of patient care will inevitably suffer.

In Brighton and Hove, The Practice Group terminated its contract for five GP surgeries in the city at the end of June 2016, leaving 11,500 patients looking for a new GP.

Over the years, The Practice Group, which runs around 50 GP surgeries, has also closed a surgery in Camden Road, London, the Maybury surgery in Woking, the Brandon Street practice in Leicester and the Arboretum surgery in Nottingham.

All these surgeries were in areas of high deprivation, where it is difficult to make money. The Practice Group defended terminating the contracts and closing services, saying that loss-making activities were unsustainable.

**40%**

**of hospital trusts' non-clinical support services are outsourced to private contractors**

## The private sector doesn't share the risk

Private sector providers draw up eligibility criteria to determine which NHS patients they will accept for treatment, and frequently this means the more complex and costly cases end up receiving care in the NHS. This is a feature of health systems with public/private partnerships.

GPs have accused private providers of cherry-picking, by attracting younger patients to their lists. This has left some surgeries struggling with a skewed patient list - a greater proportion of patients who require more care and GP time, but with no extra funding to provide it.

A study of the Scottish NHS found that increased use of the private sector was associated with a significant decrease in direct NHS provision and with widening inequalities by age and socio-economic deprivation.

## Diverting resources away from the NHS

For the last decade the experiments with competition and outsourcing have coincided with an unprecedented squeeze on NHS funding.

Workforce, buildings and equipment have all needed significant investment, to adjust to the rising numbers of older people and increasing chronic disease, but instead, the NHS was forced, year on year to search for unrealistic levels of savings.

Academic analysis has argued that policies to encourage greater private sector involvement tend to coincide with

underfunding of the public sector and are associated with a government trying to progress a privatisation agenda, often fired by the belief that firms will cost less and improve services.

## Benefits … at a cost

International research has confirmed that any benefits of involving private health care come at a cost.

A study that collected evidence across 107 low- and middle-income countries to compare the impact of public and private healthcare providers concluded that the private sector more often violated medical standards of practice and had poorer patient outcomes but had greater reported timeliness and hospitality to patients.

## Public healthcare is more efficient

A study by the WHO found that public systems tended to be more efficient than private.

The NHS performs well in international comparisons of health systems.

The experiment with marketization and greater involvement of the private sector has resulted in a rise in bureaucracy and administration costs throughout the NHS.

In systems where public provision is lower, there are perverse financial incentives that add costs and undermine continuity of care.

Overtreatment of patients is more common, companies do not share patient information and tests are repeated.

## Who pays to train staff?

The NHS trains most clinical and scientific staff. Some go on to work in the commercial sector, but a larger private health sector is an inevitable drain on the staffing resources of the NHS.

Where private hospitals take on a large amount of NHS surgery it can affect the local NHS hospitals as their surgeons do not get the same mix of cases with which to develop their skills.

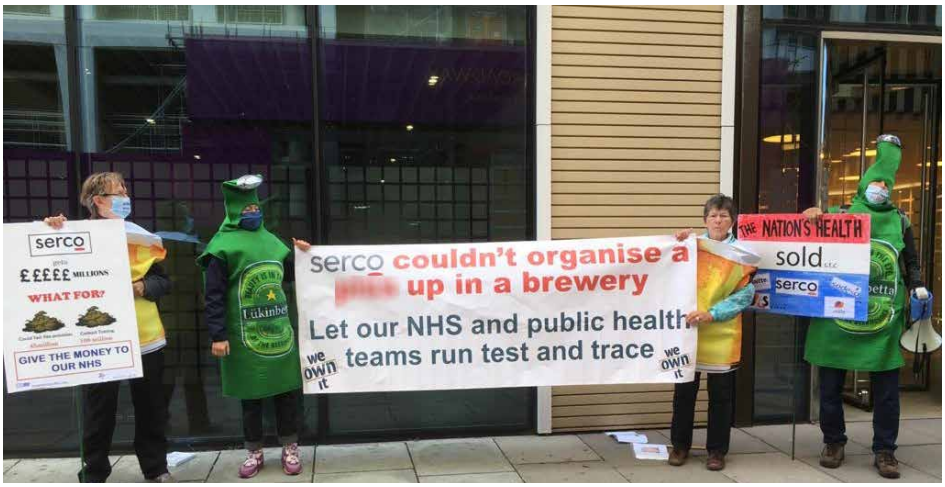
## No transparency

The public deserves to know who is providing their care, but often companies hide behind the NHS logo, and patients are not informed that their care has been outsourced to another provider or are not given a choice to remain inside the NHS.

During the pandemic, normal tendering rules have been suspended.

Commercial companies with the right political connections have landed lucrative deals with the government, trampling over the normal safeguards.

Ministers are being dragged into the courts to force them to reveal information about a series of dubious covid deals, despite the clear public interest in seeing that funds were properly and wisely spent.




**11%**

**The share of NHS spending going to non-NHS care in 2019/20, although this figure misses out some expenditure on NHS-funded social care.**

**According to NHS accounts for 2019/20, LOCAL commissioners (CCGs) spent around**

**15%**

**on average, with the largest spenders allocating up to**

**26%**

**of their budget with private providers**

**A third**

**of NHS HIP OPERATIONS, and**

**a quarter**

**of CATARACT OPERATIONS are performed in private hospitals.**

**30%**

**of MENTAL HEALTH HOSPITALS are privately run**

**44%**

**of health funding for child and adolescent mental health care goes to private companies.**

## Undermining the covid response

Throughout the pandemic, outsourcing has rapidly accelerated and normal safeguards are suspended.

The strategy of bypassing the existing network of NHS labs and the council tracing facilities has caused delays and reduced the effectiveness of these services at a crucial time in the response to the virus.

Healthcare workers reported that they were not provided with adequate PPE, leaving them exposed to the virus.

Serco and Sitel have been awarded contracts (valued at £108 million) to support the government's test and trace strategy and yet centralising contract tracing has consistently failed to reach effective levels and performed less well than public health run services operated by contract tracers with local knowledge.

Eight months into the pandemic Independent Sage group concluded

"it's clear that England's find, test, trace, isolate and support (FTTIS) programme is failing, leading the government to rely on a succession of restrictions on people mixing to control the pandemic.

"The result is that the UK has some of the greatest excess death rates and economic damage anywhere."

# Pandemic billions squandered on private providers

## Billions wasted on dodgy PPE deals …

The government response to the unprecedented event of the pandemic has been unprecedented in scale, spending **£12.3 billion** on **6,900** contracts for 32 billion items of PPE by July 31 – but most of it has also breached any normal rules of transparency, according to the National Audit Office.

Only 25% of these plans were published within the 90 day target.

The NAO revealed a "high priority lane" was established to assess potential providers referred by government officials, ministers, MPs and Lords as well as health professionals: companies on this list of 493 were **ten times more likely** to secure contracts than the **1%** of almost 15,000 companies in the ordinary lane that were successful.

New contracts totalling **£17.3 billion** for various goods and services were awarded to suppliers, of which **£10.5bn** (61%) were awarded directly with no tender process, and just **£0.2bn** (1%) were awarded using any competitive bidding process.

That's why PPE procurement has become a by-word for cronyism, with ministers' friends, relations and Conservative political donors apparently favoured over companies best placed to deliver the quality and quantity of PPE required.

Questions have been raised over the propriety of dozens of contracts awarded to companies with little if any relevant experience, few if any staff and no apparent qualifications, as well as the poor quality of masks, gowns and other goods supplied.

While so many individuals and companies have lined their pockets from PPE contracts, even now safety concerns have prompted a coalition of more than 20 health and science bodies to write to the prime minister urging him to order a review of UK rules on infection prevention so that workers are provided with higher-grade masks: the Independent has found some trusts are having to break the rules to provide more appropriate and safer face masks for front line staff.

## Hancock -- "there was no shortage of PPE"

Matt Hancock has angered health and social care workers by insisting in an interview with Andrew Marr that there was no national shortage of personal protective equipment (PPE) during the first wave of the Covid 19 pandemic.

Hancock insisted on three occasions that the UK "didn't have a national shortage of PPE".

However a *NursingNotes* survey of healthcare workers following the first wave of the pandemic showed that **over half** of workers (52%) had been given PPE they felt was inappropriate or inadequate, **a third** had been told to re-use single-use PPE, and **a fifth** had been given PPE that had already expired.

Mr. Hancock's claims came only days after healthcare leaders wrote to the Prime Minister again calling for improved PPE.

Across the UK, at least 930 health and care workers to date have died and many more are suffering from long-term adverse effects of COVID-19.

## … Supply Chain …

NHS Supply Chain is technically a holding company owned by the Secretary of State for Health and Social Care, but in practice it is an immensely complex and dysfunctional web of contracts established in 2018.

The system, designed by Deloitte was supposed to deliver "efficiency savings". In reality, supplies of vital PPE were rationed and the country left unprepared, severely undermining the national effort to protect NHS, care staff and patients.

The major companies involved are:

- **DHL**, the parcel delivery company, which is in charge of finding wholesalers to supply ward based consumables, including PPE kits and boasts that it originally helped to privatise "the government purchasing and supply agency and logistics agency"
- **Unipart,** responsible for delivering PPE through its £730 million NHS logistics contract. Unipart's CEO promised to 'cure the NHS' in 2013 but its "just in time" approach goes against the need to stockpile medical goods, such as PPE.
- **Clipper Logistics,** whose chairman Steven Parkin donated £725,000 to the Conservative Party in the last 5 years, has also been contracted to run a separate PPE channel for NHS Trusts, GPs and care homes.

## … and Test …

At the start of the COVID-19 outbreak Public Health England (PHE) carried out comprehensive test and trace activities for the relatively low numbers of infections, but in mid-March ministers suspended comprehensive contact tracing and turned to a national lockdown as the main way of reducing transmission of COVID-19.

As the pandemic took hold, ministers were

not only slow to take WHO advice and put vital testing measures in place, but insisted on doing this not through local NHS or primary care but through private contractors in a system devised by city consultants Deloitte.

By the end of April sub-contractors including Serco, Sodexo, G4S, Mitie and others were belatedly opening up a scattered network of 31 testing sites across the UK, with just one is in Wales, three each in Scotland and Northern Ireland, leaving just 24 to cover the whole of England, with huge areas lacking any testing centre.

The Sun argued that "Matt Hancock needs to stop pretending his coronavirus testing strategy is anything but a fiasco".

## … and Trace

It was not until May that "NHS Test and Trace" was set up, headed by Tory peer Dido Harding, to establish and run a national tracing system. It was not provided by the NHS, and largely bypassed the existing local networks and expertise of public health experts.

Instead it was designed by a small army of Deloitte consultants on fees of £1,000 per day, and once again brought in Serco – a company with a long track record of contract failures – to deliver the service, along with call centre provider Sitel.

However 85% of the actual tracing work was further sub-contracted to smaller companies who employed many of the 18,000 workforce on zero hours contracts.

**The Test and Trace budget has grown to a massive £22 billion for 2020-21, the bulk of it assigned to testing, and just £1.3bn on tracing contacts, £720m of which is allocated to contracts with Serco and Sitel.**

Sitel has also had the much smaller contract (£664,000 over the first four months) to run the Isolation Assurance Service that is supposed to check international arrivals quarantine as required: but according to *Private Eye* (February 19) **out of 2 million** international arrivals who left their contact details with Border Force, Sitel's call centre spoke to **just 66,773** of them, and phoned an additional **83,000** who did not answer.

Polling shows that a large majority (74%) want local public health teams rather than Serco and Sitel to run NHS Test and Trace, and local councils and campaigners have been pressing for this change of policy.

**Private companies have not offered a holistic approach because they see themselves as having responsibility for only a small part of the system.**

**This reflects a wider trend where privatisation leads to fragmentation. This is echoed in their targets being limited to providing a certain number of call handlers and a working phone line, and the lack of any penalty clauses for persistent failure to reach sufficient contacts.**

By September 16 the prime minister, appearing before the Commons Liaison Committee, admitted that the testing system had "huge problems."

Even in November (when the government changed how they measure the percentage of contacts reached), Test and Trace statistics for England showed that the national, remote contact tracing operations run by private outsourcing companies Serco and Sitel had reached less than two thirds, just **58.5%** of people's contacts to ask them to self-isolate in the previous week.

This fell well short of the 80% required to be effective – and at a reported cost of £900 per person contacted.

By contrast the schemes run by local public health teams have reached an average of **97.9%** of identified contacts to ask them to self-isolate since the system was set up.

This is the model in other countries which have been more effective at tracking and tracing Covid19 infection.

**We Own It is a voice for the public and for public service users. We campaign against privatisation and for 21st century public ownership.**

# Hancock broke the law on PPE contracts– court judgment

**On February 19 the High Court ruled that the government had acted ulawfully by failing to publishe details of Covid-19-related contracts within the relavant timeframes.**

**While the BBC and much of the media has maintained a tactful silence over this setback for Matt Hancock, the Good Law Project, which raised the funding to mount the successful legal challenge, is calling the vluff of ministers who have claimed that the government is committed to "learning lessons" from the judgement.**

**They have written to demand ministers take four concrete steps in the right direction – and offering to hold back on follow up legal challenges if they comply.**

**The four proposals are:**

- **Publish names of companies who went through the VIP lane, who introduced them, and, where they were successful, the prices they were paid.**
- **Commit to recovering public money from all the companies who failed to meet their contractual obligations.**
- **Commit to a judge-led public inquiry into the handling of PPE procurement during the pandemic.**
- **Commit to following the lead of other jurisdictions by publishing PPE contracts with pricing details visible to enable proper scrutiny.**

**Whether ministers will be shamed into such commitments remains to be seen -- but the issue is by no means concluded.**

# Outsourced staff treated as second class citizens

## 37 years of contract failures

**Outsourcing NHS non-clinical support services began in earnest under Margaret Thatcher's government from 1984. Cynical claims of "efficiency" and "cost savings" thinly masked the aim of opening up part of the NHS budget to profit-seeking private contractors, many of them – as with today's PPE contract scandals – Tory cronies or donors.**

By the end of 1984 there was already a long and growing list of contract failures against some of the main players as standards of hygiene began to collapse as fewer staff were given fewer hours on lower pay to do labour-intensive work. But the policy was driven by ideology, not evidence, and the privatisation drive continued.

**Hospital cleaning became a byword for failures**. Memories of this are no doubt part of the reason why a majority of the public in the run up to the last election made clear they were against transferring staff out of the NHS to contractors. Half of those polled feared that privatisation could undermine the efficiency of the NHS.

More than three quarters of those asked also believed non-clinical support staff were just as important to the NHS as doctors, nurses and midwives.

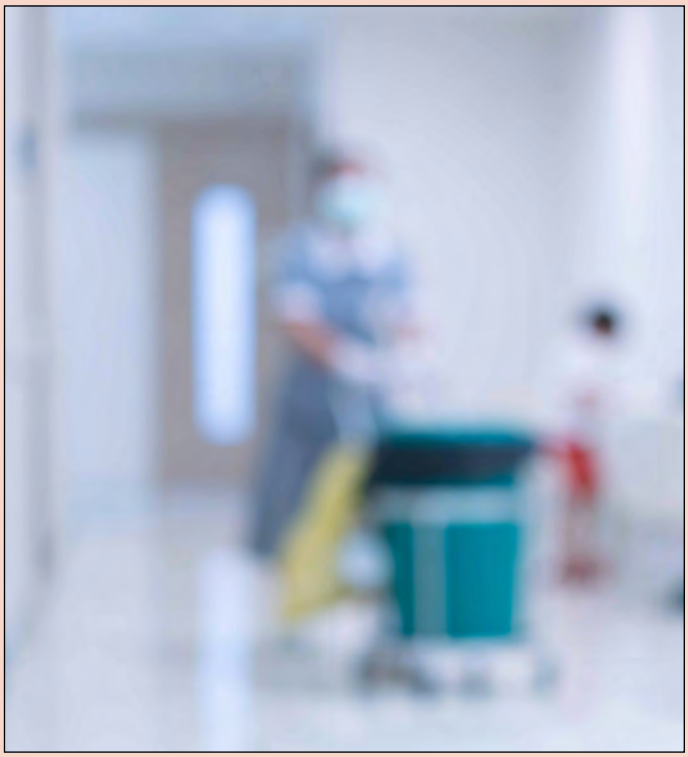
### Infection

**Twenty years later in 2004** the problems created by driving down the price and quality of cleaning standards were being belatedly recognised.

New Labour Health Secretary John Reid argued that one reason for the spread and proliferation of one of the most serious hospital acquired infections, MRSA, had been the Tory government's decision to contract out cleaning work, with contracts going to the lowest tender.

**At the end of 2004 a national report from the Patient Environment Action Teams (PEATs) found that while just over a third (440) of the 1184 hospitals surveyed employed private contractors, 15 of the 24 hospitals deemed "poor" were cleaned by private contractors – suggesting that the incidence of poor cleaning was twice as common among privatised contracts.**

In 2016 a major research project which analysed 126 hospital trusts found that the average incidence of MRSA was 50% higher in those with outsourced cleaning compared with those using in-house staff.



And while outsourced services were marginally cheaper, the difference was around £236 per bed per year — equivalent to just £118,000 in a 500-bed hospital.

One co-author Prof David Stuckler stated that contracting out "may save money, but this is at the price of increasing the risks to patients' health. … contracting may prove to be a false economy," while another co-author Prof Martin McKee summed up

"These findings suggest that what many had suspected is actually true. Outsourced services pose a risk to staff, patients and the wider population."

51 of the 126 trusts (around 40%) sampled had outsourced cleaning services.

### Cheap and dirty

This was also the proportion found in a separate 2019 study looking at data from 2010-2014, which also concluded that "private providers are cheaper but dirtier," with lower levels of cleanliness and worse health care outcomes in terms of hospital acquired infections.


**By John Lister**

Despite almost four decades of failures, and the latest spin claiming the new White Paper rejects contracting out and competition as a driver of efficiency, there is no indication of any plans to rein in or roll back outsourcing of support services, or properly integrate the workforce that keeps the NHS going.

The latest NHS Digital figures also show that government and many NHS managers have learned almost nothing: the NHS has further reduced its workforce of hospital cleaners by 1,000 since 2010, and cut spending on hospital cleaning, underlining that it still is not seen as a priority – even as the pandemic has put a premium on infection control.

## Putting patients and staff at risk

The problems of poor quality services been compounded during the pandemic by inferior contracts from private companies that do not offer staff pay for the first three days off sick, or guarantee pay for workers required to shield from threat of Covid infection.

**By contrast NHS Employers last summer agreed that NHS staff who had to shield and cannot work from home should receive full pay throughout this "special leave."**

The refusal to fully cover sick pay for low-paid workers creates a perverse incentive for those who have tested positive to continue to work rather than lose vital income – especially if they have few actual symptoms – potentially spreading the virus.

A Channel 4 survey in March 2020 found that three quarters of outsourced staff felt forced to come in to work when ill, and avoid any engagement with Test and Trace which might find them infected, because they could not survive on the miserly £96 per week statutory sick pay.

**75%**

**of outsourced staff felt forced to come in to work when ill, and avoid any engagement with Test and Trace according to a Channel 4 survey in March 2020**

**1,000**

**hospital cleaning jobs have been axed since 2010**

**77%**

**of outsourced support staff at Homerton hospital are from an ethnic minority community**

**£95.85**

**the weekly level of Satutory Sick Pay for many outsourced staff – far worse than the entitlements for NHS-employed staff doing similar work in other trusts.**

In Homerton Hospital, in Hackney, UNISON and GMB last July flagged up that over half of the 200 workers outsourced to facilities company ISS were not receiving sick pay for the first three days of their illness, after which the key workers receive statutory sick pay of just £95.85 per week, a significant reduction from a salary of £80 to £100 a day – and far worse than the entitlements for NHS-employed staff doing similar work in other trusts.

Statistics also show people from BAME communities are more likely to be seriously ill or die if infected by Covid: but the sections of low-paid staff outsourced also tend to be disproportionately made up of black and minority ethnic staff, especially in urban areas. In Homerton, for example, 77 per cent of the 200-strong outsourced workforce is from an ethnic minority community, and councillors warned that by extending the contract by another five years the Trust "locks in disparities".

## Super-spreaders

This is even more significant given research last summer that showed outsourced support staff had much higher levels of antibodies from having been infected than 'front line' clinical staff, making infected staff likely unwitting "super-spreaders" of the virus.

Estimates suggest 20% of Covid-19 infections occur in hospital: this makes privatisation and the inferior terms and conditions of profit-hungry companies bad for patients, and an obstacle to the fight to contain the virus.

No similar studies have been done on transmission of the virus by ambulance and patient transport staff but ambulance staff in south London working on non-emergency patient transport for private company HATS were told in March 2020 – as the pandemic

gathered pace – that there was no PPE for them. The message was to 'get it off the NHS' if you need it'.

But the exposure of non-clinical staff to Covid-19 can also be lethal for staff; in St George's Hospital three cleaning staff employed by profitable contractors Mitie died after contracting Covid-19.

Nonetheless, while most of the leading contractors (Medirest, ISS, Sodexo, Interserve, Serco and Mitie) have eventually agreed to guarantee full pay for all health workers self-isolating, to secure continuation of pay for staff who are obliged to shield, hard line employers like Engie, OCS, Serco and G4S have obstinately refused.

## Support cut off

Some companies that agreed to do the decent thing on sick pay while government money was available to enable trusts to shell out and underwrite the company's costs and preserve their profits, have not necessarily stuck to the promise since things changed last autumn.

Last September the government told all public bodies in that it would be withdrawing its 'supplier relief instructions' which urged NHS trusts, to ensure suppliers continued to be paid for their services - even if they have been switched off as a result of Covid-19.

To make matters worse the centralised pot of money available to trusts via NHS Improvement to help cover full sick pay for staff has now been cut.

Mitie, one of the largest service providers, has pulled back from any commitment to full sick pay, leaving staff to struggle by on statutory sick pay – and even, it is alleged, demand they work on, even when potentially infected with Covid.

With trusts like West Hertfordshire Hospitals and grasping corporations like Mitie now both simply denying any responsibility to maintain full sick pay for 400 outsourced staff, the GMB and shadow health minister Justin Madders have demanded urgent action.

## The pay gap

When NHS staff are transferred to a private contractor, TUPE regulations give them some limited protection of their terms and conditions at point of transfer, and there is a limited provision for transferred staff pension rights under "Fair deal for Staff Pensions".

However TUPE is static, meaning that staff are no longer automatically included in pay increases awarded for NHS staff, and are likely to have to switch to a company pay scale if they are promoted or change job. It also only covers staff transferred, so is soon undermined as inevitable turnover of staff means new starters are brought in on inferior company terms and conditions – generally lower pay, minimal sick pay and fewer days holiday.

While similar staff in Scotland are covered by a two-tier agreement with unions signed by the Scottish government, which ensures that staff employed by contractors delivering "soft" support services receive pay and conditions no less favourable than Agenda for Change, in England a very different two-tier workforce – with outsourced staff as second class citizens – remains an issue for thousands of low paid workers.

**£9.30**
**hourly rate for outsourced security officers at Royal Berkshire Hospital**

**£10**
**the hourly rate hour for supervisors**

**400**
**the number of outsourced staff denied full sick pay by Mitie and West Hertfordshire Hospitals Trust**

**£2,000**
**increase in pay for lowest paid NHS staff in 2018 pay settlement that left out thousands of outsourced staff**

In the 2018 NHS pay settlement thousands of outsourced staff were left out of a deal that raised pay for the lowest paid NHS staff doing the same jobs by £2,000 per year. The government decided not to give trusts the funding to ensure that outsourced staff would get the same.

## Cut off from training

Outsourcing doesn't just affect immediate pay and conditions, it also affects career prospects and access to training and development.

NHS employment preserves the possibility of being able to access career pathways which, when available, enable staff to progress from lower paid roles to higher paid ones and to train from non-clinical roles to qualify into clinical ones – thereby retaining experienced staff for the employer and improving quality of life and job satisfaction for the staff.

Private companies, focused on the need to maximise profits and minimise costs, offer no such possibilities: the continuation of outsourcing locks in the second class status of thousands of staff.

## Pay disputes

This brazen injustice, especially where contractors' staff remain on the national minimum wage, has triggered a succession of disputes, notably 14 days strikes by employees of Compass in the North West **(Blackpool, St Helens and Whiston)** which won significant improvement on pay and sick pay just after the last election.

In March 2020 600 cleaners, porters and catering staff employed by Sodexo and Interserve at **King George Hospital Ilford and Queens Hospital in Romford** won a pay rise of £2.54 per hour, from the national minimum wage to £10.75 in a recognition by the Barking Havering and Redbridge trust of the coronavirus challenge faced by staff.

Sodexo's statement made it quite clear that the generosity had come from the Trust rather than the company.

Also last March angry staff at **Lewisham Hospital** who had been promised in November 2019 an increase from £8.21 per hour to the London Living Wage of £10.55 by contractors ISS staged strikes when they found their correct wages had not been properly paid.

In May 2020, contractors **Medirest** agreed a deal to increase the pay of 2,200 cleaning, portering and catering staff working in NHS hospitals across England by an average of 5% from the beginning of next month to £9.21 an hour, bringing their pay in line with NHS staff doing similar jobs.

In August 2020 cleaners at **Luton & Dunstable Hospital** won a guaranteed step up to full NHS pay of £9.21 per hour as soon as the Engie contract ended in November. However they could not get the Trust to bring them back in-house as NHS employees, and a new private employer was being lined up to take over.

Also last August cleaners, porters and security staff at **Hackney's Homerton Hospital** fell short of NHS equivalent pay, pensions, overtime and annual leave even though they won a guaranteed increase to the London living wage and NHS equivalent sick pay 'from day one' as contractors ISS won a new 5-year contract.

A deal last December won 50 outsourced maintenance staff, including electricians and plumbers, at **Norfolk and Norwich University Hospital** a useful 4.5% pay increase from Serco, narrowing the gap between their pay and the higher NHS rates paid to colleagues elsewhere in Norfolk.

Meanwhile in **Reading** privatised security guards at **Royal Berkshire Hospital** are still embroiled in protracted strike action demanding an increase from the miserly £9.30 an hour for security officers and £10 an hour for supervisors to £12 and £13.

Meanwhile in **Carlisle** as this Briefing is prepared Mitie, the hospital trust and the PFI consortium Health Management Carlisle are squabbling over who is responsible for paying 150 workers unsocial hours payments that have been missed for a decade, with UNISON and GMB holding crunch talks in a last-ditch attempt to avoid strike action.

The staff concerned (and presumably



*Campaigning against private contractors and WOCs – clockwise from top left: Homerton, Bradford, Princess Alexandra Hospital and East Kent*



the main responsibility for paying them) were transferred to Mitie when it bought the facilities management business from Interserve last December.

## Getting back (and staying) in house

NHS pay scales, terms and conditions remain the gold standard, and 2020 has seen a major London trust bring 1,000 staff back in-house, while **North West Anglia Trust** was forced back from outsourcing an award-winning catering department, portering, logistics and linen services at Hinchingbrooke Hospital.

The deal last January to bring 1,000 support staff at the five hospitals of **Imperial College Healthcare Trust** back in house represented a significant achievement, and followed strike action by 200 members of United Voices of the World at **St Mary's Hospital** in Paddington.

The deal meant that from 1 April the staff were longer be employed by Sodexo, which had held the contract since 2015, and saw their pay, overtime, pensions and sickness allowances brought in line with other NHS staff with pay increased from £10.55 to £11.28 an hour and sick pay from the first day they're ill.

Workers also gained access to the NHS pension scheme, which was previously unavailable to them as Sodexo staff.

The **Hinchingbrooke** campaign highlighted the quality of services provided by the in-house team, but also noted the North West Anglia trust's discrimination against outsourced staff, who were excluded from the specific support it was providing to its clinical staff during the Covid pandemic.

## Subcos

The last 3 years has shown a major trend of NHS Trusts creating subsidiary companies, known as Subcos or Wholly Owned Companies (WoCs).

As trade union negotiators and campaigners have shown, this has been done to get tax advantages, despite the hype and even downright lies about it being in order to improve services.

**Staff affected are generally low paid, and disproportionately women and from BAME backgrounds.**

They are often regarded by NHS Trusts as "other" as they deliver vital but poorly recognised services like cleaning, catering, portering, and other jobs covered by the facilities management description.

Local campaigns have succeeded in stopping some of the proposed subcos, notably in **Princess Alexandra Hospital**, Harlow, and in **Mid Yorkshire**, where the threat of strike action helped persuade management to retreat, and after longer campaigns and action in **Wrightington, Wigan and Leigh**, **Bradford**, **Frimley**, **Bolton**, **and Tees, Esk and Wear.**

The process has to a large extent been stalled since before the pandemic, but there are fears that a queue of trusts are waiting for the opportunity to come back again with new proposals that would offer limited financial benefits – once again at the expense of their low-paid staff.






# An appeal from The Lowdown

Dear Reader,

**Help us to keep investigating and publishing information to help protect our NHS.**

We hope that you find this special collection of articles about the impact of NHS privatisation useful. It is crucial to get the facts about what is happening to the NHS to a much wider audience.

This document was put together for you by a small but dedicated team of researchers and journalists, who believe in making this information freely available.

**We need your help to keep on producing content like it, so if you can please support us with a donation today.**

We produce campaigning journalism and research for the public and in January 2019 we published the first pilot issue of The Lowdown - it is published bi-weekly, and is freely available.

It is unique. It breaks new stories – like the takeover of GP surgeries by US giant Centene – and stories you won't find elsewher: it explains policy, investigates issues and connects NHS supporters with campaign work. It fills a gap that no other publication can fill. It equips readers – trade union activists, campaigners, academics – with evidence based and up to date information.

You will know that for many years, the NHS has struggled to keep up with the needs of patients, undermined by flawed government policy.

The issues are complex, misinformation is rife, and the public needs early information


about threats to the NHS and its services.

**We provide information free to access: but it is not free to produce – and we have no billionaire backers.**

We have been kept going up to now by generous donations from a few trade union bodies and individuals. To keep it going and expand to take on the new challenges ahead we need more money to recruit, train and pay expert staff.

**So if you can, please support us with a regular donation or an affiliation, and if you are a trade union member urge your branch and/or region to make a donation too.**

You will be helping our team of journalists and researchers to work on the crucial issues of how to build NHS capacity, and prevent privatisation in the wake of the pandemic.

You will be helping:

- to provide analysis about what's happening to the NHS and why
- to develop an antidote to the frequent misinformation from ministers.
- to report on the ideas that can create change, and the work of campaigners, trade unions, and NHS staff – to help build an effective network of NHS supporters.

## The challenge is urgent

The mighty effort taking place now to fight Covid comes after a decade of underinvestment in NHS staff and equipment, wasteful reorganisations, and growing privatisation of services.

It is crucial to help the NHS to adapt to the rising demands of our population.

Recent history tells us that we cannot leave it to our politicians to adequately support the NHS – and therefore the public and NHS staff must be involved.

The NHS is crying out for more investment in its fantastic workforce, but despite our politicians' claims, funding is still grossly inadequate, while huge sums are squandered on wasteful deals with the private sector.

**If you can, please donate to help fund our work so we can improve public awareness and challenge our policymakers to build a more sustainable NHS.**

Thank you for all your support.

**Dr John Lister and Paul Evans and The Lowdown team**






**Please donate to help support The Lowdown's campaigning NHS research and journalism**

# Mega-laboratories: a Trojan Horse for a private system


**Based on a report by Pat McGee**

With the total Pathology budget within the UK worth more than £2bn, technology and diagnostic companies are keen to cream off a large slice of this for private profit.

Ministers appear not only to be utilising interim powers under emergency Covid-19 legislation to facilitate this privatisation but are allowing private providers to make savings by circumnavigating national standards designed to ensure quality pathology services.

At the start of the Covid pandemic, a number of 'Lighthouse Laboratories' were set up in addition to, and in most cases independently of, NHS laboratories, in order to carry out Covid testing.

**The majority of these facilities are provided by the private sector.**

Companies involved in the Lighthouse programme so far include Medicines Discovery Catapult, UK Biocentre, GlaxoSmithKline, AstraZeneca and PerkinElmer, and the DHSC also has 'partnership agreements 'with other commercial providers – the latter including Randox in Northern Ireland – to assist in the covid-19 swab-testing programme.'

It appears that there was no requirement for these laboratories and their staff to be regulated, leading to concerns regarding the quality and safety of the services provided.

In April 2020, a worker at the Lighthouse laboratory in Milton Keynes, run by UK Biocentre, told the Guardian that the facility had received hundreds of swabs in vials that were either leaking or not sealed in two bags as required, meaning the couriers and technicians handling them risked contamination.

Six months later a joint investigation by the BBC and the Independent revealed further problems at the site, and highlighted overcrowded biosecure workspaces, poor safety protocols and a lack of suitable PPE.

## Bypassing the NHS

Numerous NHS laboratories, including the Coventry and Warwickshire Pathology Service, already had the facilities, expertise and existing accreditation to provide molecular testing.

This was extended at the beginning of the pandemic to include Covid-19 PCR testing within hospital environments. These laboratories could therefore, with some investment, have provided comprehensive community Covid-19 testing.

**A BMA report published in September noted that 44 NHS pathology labs were left under-used during the height of the pandemic, and that outsourcing resulted in "significant adverse effects".**

It gave one simple example: delays at Lighthouse labs had on occasion left hospital staff unaware of their Covid status for up to seven days while awaiting test results… when NHS facilities could have determined those results in just six hours.

The Institute of Biomedical Science has also been critical of the strategy. 'Whilst we recognise the need to rapidly upscale testing capacity and the fact that this will be an ongoing requirement, we have consistently voiced our members' concerns about the centralised approach to testing.

This has led to the creation of the lighthouse laboratories as a parallel but disconnected testing stream for COVID-19 and there has been a lack of transparency around processes of clinical governance and, in particular, the limited IT connectivity of these laboratories to clinical systems already in place.

There was also no facility for IT links, essential not only for safe and effective patient care, but also for effective Track and Trace services at local level.

**Using the NHS, results would have been entered into the Laboratory Information Management System (LIMS), with automatic upload to each patient record in the relevant hospital system, which is accessible by hospital staff and GPs providing patient care. Reports could also have been submitted electronically to the patients' GPs from the LIMS.**

It would have been relatively simple to provide local Track and Trace services with timely notification of all positive tests, to include patient demographics from the NHS patient database and to include addresses.

Such notifications from the national Track and Trace system provided by Serco have been delayed and often lacking the necessary information for effective local control measures to be implemented in a timely manner.


## A New 'Mega-lab' in Leamington Spa

In November 2020, it was announced that Leamington Spa had been selected as the site of one of two new 'Mega-labs' in the UK (the other in Scotland) for large scale Covid-19 diagnostic testing. It could create up to 2,000 jobs in the local area and would be 'one of the largest diagnostic facilities in the UK'.

The NHS run Coventry and Warwickshire Pathology Service (CWPS) already employs more than 500 staff, including Medical Consultants, Clinical Scientists and Biomedical Scientists. Support staff include Biomedical Assistants, who are unqualified but are highly trained and supervised.

So far recruitment ads for the new centre have not included Biomedical Scientists, a title which is protected for use only by individuals who are State Registered, and therefore regulated by, the Health and Care Professions Council.

The laboratory is instead using titles such as 'Senior Laboratory Technician'. Which does not require applicants to have a degree in Biomedical Sciences, or to be State Registered with the HCPC.

Adding to concerns that the mega labs are a duplication is evidence that NHS staff are being poached to work in them.

The IBMS told the Lowdown: "recruitment agencies working for Lighthouse labs have been directly approaching Biomedical Scientists working in the NHS to offer them enhanced salaries to tempt them to leave the NHS."

After a decade of pressure on funding staffing in pathology is at crisis point with only 3% of diagnostic labs claiming to have sufficient staff – and this is a cause of backlogs and case outsourcing.

**2,000**

**number of jobs to be created in the Leamington Spa mega-lab**

**3%**

**of NHS diagnostic labs claim to have sufficient staff**

**£2.25bn**

**15-year turnover of pathology network for South East London**

## Part of a plan to privatise

Health Secretary Matt Hancock claims "The radical expansion of testing has been one of the successes of this pandemic, as it means more people can get a test more conveniently than ever before.

"We didn't go into this crisis with a significant diagnostics industry, but we have built one."

Hancock's claim that the UK did not have a 'significant diagnostic industry' trashes the existence of the established, but underfunded, NHS-run pathology service.

The NHS has 44 virology labs and the independent sage group of scientists suggest the underuse of NHS facilities undermined the response to the virus at a critical stage contributing to the higher death toll.

Hancock's silence about the private ownership of the new Mega-labs conceals the real agenda of this government, which is to establish and entrench a privately run health pathology system bypassing and running in parallel with the NHS diagnostic and pathology service, a process which was well underway prior to the pandemic.

It was reported in the Lowdown - Oct 2020, that the SE London Integrated Care System ('Our Healthier South East London' – OHSEL) has been overseeing the drawing up of a huge pathology network contract for South East London.

The estimated value is a staggering £2.25 billion over 15 years (with a 5-year extension option). SE London Clinical Commissioning Group (SELCCG) has now given the green light to the private company SYNLAB.

Putting in perspective In 2018 BMC Health Services Research found that this consolidation of pathology services in England had already been matched by a significant increase in private sector involvement, reaching 13 per cent of the total pathology budget, but this proportion will have advanced significantly since then.

It added, "The interest of private sector in providing pathology services should not come as a surprise.

"The total pathology budget is worth more than £2bn and there is a wide range of technology and diagnostic companies that would like a share of it."

***Pat McGee is a former State Registered Biomedical Scientist, previously employed by Coventry and Warwickshire Pathology Services (CWPS) at University Hospitals Coventry & Warwickshire NHS Trust (UHCW). She is Secretary of the UHCW Branch of Unite the Union and Chair of Coventry Keep Our NHS Public***

The full text of her article is published online by Health Campaigns Together HERE.

# The great consultancy boom – from Covid to 'Integrated Care'

**By John Lister**

Ministers and NHS management are becoming increasingly dependent on costly private sector management consultants to do the work that managers and civil servants were previously trained and expected to do as part of their jobs.

The pandemic – and NHS England's insistence on driving through the simultaneous reorganisation into "Integrated Care Systems," bringing fresh dependency on private companies specialising in apps, data and 'population health management' – has brought a massive further growth in the numbers of consultants involved.

Yet new research indicates that the NHS itself spent over £300m on consultancy in 2018/19, despite evidence that management consultants in health care "do more harm than good." Indeed the evidence is that once consultants have been brought in they "keep getting rehired" – despite their failure to improve the efficiency or quality of services.

## Test and trace

In the pandemic the current government has turned first and often to consultants for systems that could much better have been run through local government and the NHS. Last August consultancy.uk reported that 16 consulting firms had been awarded coronavirus contracts with £56m. But this was the tip of the iceberg.

January Health Minister Helen Whately admitted that 2,300 management consultants from 73 different companies (more than the civil servants in the Treasury) were currently working on the lamentable Test and Trace system, with £375m spent on consultancy for this project alone.

Other reports revealed that the consultants were being paid an average of £1,000 per day, and that Deloitte alone had 900 employees at work in test and trace. The Daily Mail estimated the total of consultants and contractors at 2,959. Sky News revealed last October that a 5-person team from Boston Consulting had been paid £25,000

**£300m**

**NHS spend on management consultants in 2018/19**

**£375m**

**Spending on consultancy for test and Trace alone in 2020**

**107**

**The number of pre-approved companies in a Framework set up by NHS England, and which can simply be awarded NHS contracts with no further tendering or competition.**

**£1,000**

**The average daily fee for 900 Deloitte consultants working on failed Test & Trace**

**83**

**The number of companies in NHS England's Hospital System Support framework, pre-approved for work Integrated Care Systems**

**22**

**of them are US based**

per day helping to "mastermind the creation of the contract tracing systems."

Last autumn, with Test and Trace "barely functional" in the face of a resurgence of the pandemic, reports indicated that hundreds of consultants from KPMG, EY and other firms were being lined up to reinforce the numbers who were already failing so badly. According to The Guardian, the additional consultants were required in areas including programme management, data, project support and supply chain – which might have been expected to already be in place.

## NHS reorganisation

Consultancy firms have played a key – and lucrative – role in most of the big reorganisations of the NHS going back at least to 1974. In recent years, a major McKinsey report commissioned by New Labour shaped many of the cost-cutting policies of NHS trusts and commissioners which aimed to generate £20bn of "savings" after the 2008 banking crash: and the incoming Tory-led coalition from 2010 employed McKinsey to help construct Andrew Lansley's large and disastrous Health and Social Care Act.

In 2016-17 the King's Fund found that management consultants were being used to support the development of STPs in three out of four areas: and firms including McKinsey were employed again and again at a combined cost of over £80m in the long running fiasco of the Shaping a Healthier


*While NHS staff battle to cope with Covid – consultants are creaming off £1,000 per day*

Future project in North West London before it was axed – only for McKinsey veteran Penny Dash to be installed last year as the chair of NW London's "integrated care system".

In 2019 NHS England paid PA Consulting over £200,000 for a 35-day "function mapping exercise" to work out what NHSE itself was responsible for: last year Matt Hancock's department brought in a team from McKinsey for six weeks at a cost of £563,000 help define the "vision, purpose and narrative" of the new body to replace Public Health England after his announcement it was to be axed.

## Framework agreement

But these ridiculous smaller projects pale into insignificance against the industrial-scale efforts to streamline the recruitment of consultants to work at local NHS trust and commissioner level with the establishment in 2018 of a 4-year "Framework agreement" with a pre-approved list of 107 companies which can simply be awarded contracts with no further tendering or competition.

# White Paper: power grab, sea change

**John Lister**

Some of the headlines and reports on the leaked draft White Paper outlining plans for a new top-down reorganisation of the NHS are quite remarkable. The Times and the BBC, clearly following a steer from Downing Street both heralded the plans as a step to "scrap forced privatisation and competition within the NHS".

In the Daily Telegraph an article by Theresa May's former chief of staff Nick Timothy also proclaims a sea-change in government policy, headlined "Covid exposed the folly of turning the NHS into an unaccountable quango" – and as if that were not enough to have *Torygraph* readers spluttering over their porridge, a sub-headline apparently questioning Margaret Thatcher's political legacy: "Years of market-based reforms have ended up increasing bureaucracy, waste and inefficiency."

There seems to be a consensus among the media reports that the new draft represents a substantial shift of policy: but is this really the case?

Sometimes the real clues to a statement lie in what is left out rather than the words it uses. Most of the 40 pages of the leaked draft are giving retrospective recognition and legal status to a fait accompli.

The mainstream media reports highlight new powers for the Secretary of State to intervene in and 'take back control' over – and responsibility for – the NHS, which were technically sacrificed in Andrew Lansley's disastrous Health and Social Care Act in 2012. They all agree that the proposals would move decisively away from the fragmentation and competition entrenched in Lansley's Act to a new focus on collaboration and "integration."

However while key sections of the Act are already being publicly flouted, much of it would remain in place.

## 42 ICSs

NHS England is already three quarters of the way through its plan to force through mergers of the local Clinical Commissioning Groups set up under the Act, to lay the basis for just 42 "Integrated Care Systems" (ICSs) which it aims to put in charge.

The remaining 13 areas have been told to complete their CCG mergers by April, or face intervention, despite grumbling from Leeds CCG chiefs and warnings from one of the pioneer ICSs, Bedford Luton and Milton Keynes that the new set-up is far from the promised smoothly integrated system, and little more than a fractious stooge body following NHS England's every whim.

And while the latest reports allude darkly to ministers' "frustration" at the


"independence" of NHS England boss Simon Stevens, there are no clear examples of what ministers have wanted to do that has not been done. Successive Health Secretaries Hunt and Hancock have repeatedly responded as if they were still in full charge of the NHS.

Giving the Health Secretary back powers to intervene earlier in controversial hospital closure plans and reconfigurations simply highlights the failure of Hunt or Hancock to block half-baked schemes – such as Shropshire, Huddersfield, and South West

The sales blurb, from privatisation enablers NHS Shared Business Services, lists ten specific areas of consultancy that are covered, including: Healthcare Business Consultancy, Leadership & Governance Strategy; Healthcare Service Business & Transformation; Healthcare Innovation & Research; Health & Community. It promotes the Framework as:

"A fully OJEU compliant route to market for the provision of multidisciplinary consultancy services; covering a wide range of specialisms. … Pricing options include day rates and also the possibility to agree innovative pricing models."

The usual big names are all there – PwC, Deloitte, EY and KPMG, along with the US big names McKinsey, Bain and the Boston Consulting Group: but consultancy.uk points out the long list also includes "boutique" consultancy firms and specialist healthcare consultancies, which have a long-standing relationship with the NHS.

## "Integrated Care"

England's NHS is being reorganised into 42 Integrated Care Systems (ICSs) with new cash-limited "single pot" funding arrangements: this brings with it pressure to increase spending on private sector management consultants, data and digital providers – and this in turn is facilitated by NHS England's establishment of the 'Health Systems Support Framework' (HSSF).

The HSSF is a 4-year £700 million framework "established to provide a mechanism for ICS and other health and social care organisations to access the support and services they need to transform how they deliver care. It focuses on specialist solutions that enable the digitisation of services and the use of data to drive proactive population health management approaches across Primary Care Networks (PCNs) and integrated provider teams."

It follows on from the 2018 management consultancy framework, and offers a pre-approved list of 83 firms, more than a quarter of which are US based, pre-approved for work on ten different "lots."

One ICS which clearly displays the extent to which it is being taken over by costly management consultants is Bedfordshire, Luton and Milton Keynes (BLMK), where the lucky winners of seemingly endless consultancy work are Carnall Farrar, who have pushed ahead with the merger of the

# or cementing in the status quo?

London – that have been referred to them by disgruntled local councils.

**However the linked proposal to remove council's right to refer contentious schemes to the Secretary of State would remove the last remnants of local accountability on plans which lack public support – and is likely to incur the opposition of council leaders.**

It's when it comes to the issue of contracting and the private sector that the silences and omissions shout louder than the weasel words in the leaked draft.

There is no plan to scrap the historic Kenneth Clarke/Margaret Thatcher division of England's NHS into a "market" separating purchasers (commissioners) from providers, and as experience in Bedford Luton and Milton Keynes shows, these divisions are still alive and well in "integrated" care systems.

There is no plan to roll back contracted out clinical or support services – or even a commitment to bring these back in-house as contracts end.

The end of the fixed tariff payment system for clinical services could actually result in more privatisation – allowing private hospitals to under-cut NHS trusts, and cherry pick low-cost simple elective cases, leaving the NHS remains saddled with more complex cases.

Removing the requirement for competitive tendering on contracts is also rather more contentious now we have had 12 months in which contracts worth billions awarded without competition for supply of PPE have yielded questionable results and triggered widespread complaints of cronyism – and criticism from the National Audit Office.

Significantly, the new rules that will offer ICSs discretion on whether or not to put contracts out to tender do not apply to "professional services."

**So the gamut of number-crunching back office services needed to deliver the Long Term Plan's focus on "digital" systems and "population health management" would still need to be contracted out, almost certainly to one of the firms in the** Health Systems Support Framework.

## Accountable?

Meanwhile there is an eloquent silence on whether the statutory ICSs would be accountable downwards to local communities as well as upwards to NHS England and ministers, and no promise they would meet in public or publish board papers.

While there will be "a duty placed on the ICS NHS Board to meet the system financial objectives which require financial balance to be delivered," there seems to be no provision to ensure an ICS allocates the "single pot" of funding for the health system fairly and with regard to health inequalities – or what would be done if they failed to do so.

Strangely, the leaked proposals would not even integrate the leadership of ICSs: while there are new powers to curb capital spending by foundation trusts, not only do NHS trusts and foundation trusts "remain separate statutory bodies with their functions and duties broadly as they are," but each ICS would require two boards.

The main ICS Board, with commissioning powers, would include NHS 'partners' and local government. The second, subordinate, ICS Health Partnership would effectively act as an enlarged Health and Wellbeing Board, also involving local government, alongside voluntary sector and, notably private ("independent") providers.

This is admitted to be a concession to complaints from the Local Government Association that councils were being left on the sidelines of ICSs – but in practice institutionalises the subordinate role of local government.

If ministers simply wanted to scrap the requirement to put contracts out to tender they could do so at any point by simply revoking the regulations that followed the 2012 Act.

Sometimes we learn more from what governments DON'T do, or DON'T say than from what they do.

three CCGs, and United health subsidiary Optum, whose representative Kane Woodley has a seat on the Partnership Board.

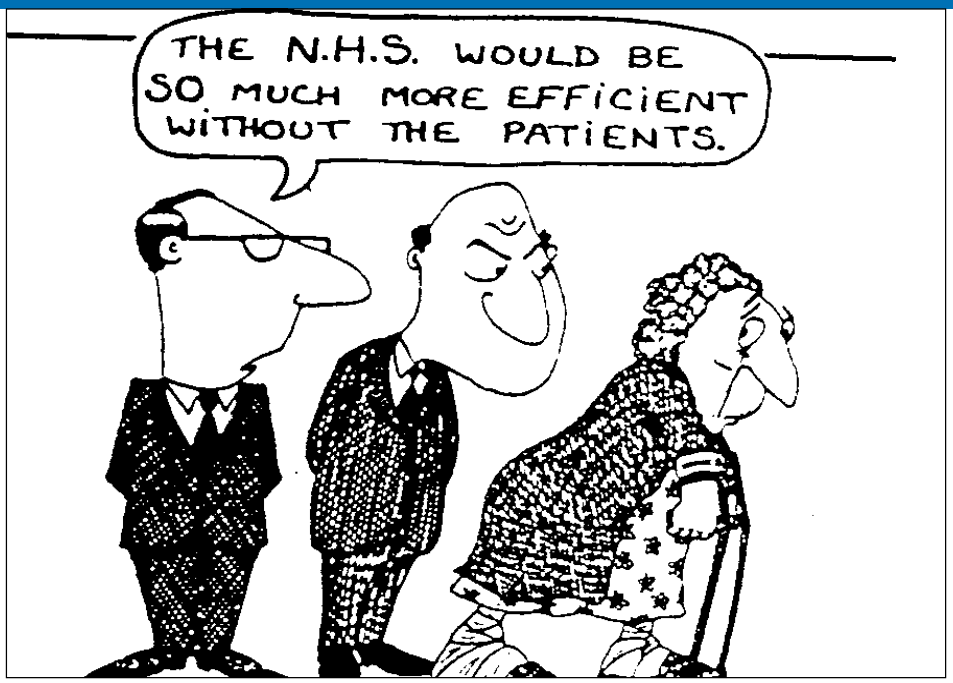
The BLMK ICS Partnership Board papers from September showed Carnall Farrar's determination to press through with the merger of CCGs into a single CCG covering the ICS area, despite the clearly stated opposition of three of the four local authorities at the July meeting.

**But they also revealed the extent to which the relative size and influence of the NHS bodies would diminish during the process of establishing the ICS, reducing any vestige of local accountability, and increasing the power and control exercised by Carnall Farrar:**

"It is expected therefore that the BLMK CCG will reduce in size over time as we implement the co-designed Target Operating Model for the strategic commissioner."

However a progress report by Carnall Farrar in February has revealed just how ineffective their bullying tactics have been in achieving any genuine integration between the NHS bodies in BLMK, let alone with the local government "partners.

And, as the ICS proposals set out in the White Paper are formulated into legislation, potentially entrenching long term and more powerful roles for management consultants, it's useful to remember the warning from the Financial Times in 2017, which drew a thinly disguised analogy between consultants and vermin:




**"The … danger is that consultants become a habit — once they get inside the building, they are hard to eradicate. They have an interest in keeping the relationship going, either by persuading clients that the challenges are complex, or by selling them more services."**

The more reliance NHS management place on management consultants, the less the focus on patient care and public accountability, and the greater emphasis on "business" methods, markets, profits … and finding new roles for even more private contractors.

# KONP launches People's Inquiry

A host of leading academics, celebrities, campaigning groups and unions together with frontline workers, have joined health campaigning organisation Keep Our NHS Public to launch a People's Covid Inquiry.

A dedicated website and campaign video have also been launched featuring testimony from members of the public, keyworkers and celebrities, which will aid the publicity and public accessibility of this important project.

In the absence of an arranged formal public investigation, campaigners believe that the time for a Covid Inquiry is now, in order to analyse why this country has suffered over 100,000 deaths, and what lessons should be learned to inform future decision and policy making.

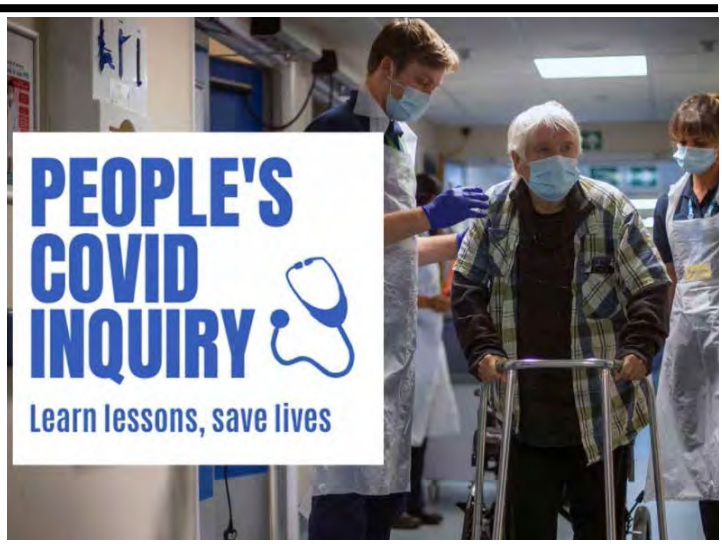
**Overseeing proceedings will be the renowned human rights barrister Michael Mansfield QC.**

Participants will include:

- Green Party MP Caroline Lucas,
- Chair of Independent SAGE Sir David King,
- Author and poet Michael Rosen,
- Lancet editor Richard Horton,
- Representatives from the Covid-19 Bereaved Families for Justice group,
- President of the UK Medical Women's Federation Neena Modi, and the doctor,
- Writer and broadcaster Phil Hammond.

## Eight sessions

Keep Our NHS Public will host a series of 8 online panel sessions beginning on Wednesday February 24 to be held at two-week intervals. Evidence provided by both expert and personal testimonies will be interrogated, and used to inform future sessions.




*Participants: (above)Prof Neena Modi and Michael Mansfield QC*

# The dependence of the multi-national private hospital sector on the NHS

**By David Rowland**

CHPI Centre for Health and the Public Interest

Over the past decade the multi-national private hospital companies which are operating in the UK have become increasingly dependent on the NHS for their income and revenue and receive substantial state subsidies in order to ensure their profitability and to cover debt repayments and payments to the landlords of the facilities from which they operate.

**Various government policy initiatives – in particular the "choose and book" system – have led to large numbers of NHS patients being treated in the private hospital sector, to the extent that now 1 in 3 NHS funded hip operations in England takes place in private hospitals.**

The state subsidies to the private hospital sector come in 2 forms: private hospitals are able to use NHS consultants to carry out almost all operations in private hospitals free of charge and they are also able to use free NHS ICU facilities in the event that their patients require urgent care after an operation.

## The NHS bailout of the private hospital sector during Wave 1

Like most businesses the COVID 19 pandemic initially created a serious threat to the private hospital sector as lockdown measures and international travel restrictions reduced the number of privately funded patients they could treat.

During Wave 1 of the pandemic NHS England and the Private Hospital Sector struck an agreement which meant that the NHS would cover all the operating costs of sector in return for access to their facilities to treat NHS patients.


This income allowed the private hospitals to cover the shortfall in their income caused by the lockdown restrictions and importantly to cover payments to their lenders and landlords (any default on payments to lenders and landlords could cause the companies significant financial difficulties).

To date, there is very little publicly available data on the number of patients which were treated in private hospitals under this agreement; however there are reports that a substantial proportion of private hospital facilities were unused.

There is also little reliable publicly available data on the amount paid to the private hospital in return for these services although estimates range from £850 million to £1billion.

## New opportunities for private hospitals – on terms set by the private hospital sector

Prior to Wave 2 of the pandemic, the NHS in England began tendering exercise to procure services from the private hospital sector at an estimated value of £10 billion over 4 years.

Before the pandemic, the NHS spent in the region of £1.5 billion each year, suggesting that the amount of annual NHS expenditure could potentially increase by 2/3s over the next 4 years.

The agreement struck between the NHS and the private hospital during the "second wave" did not provide the NHS with un-restricted access to private hospital facilities.

This was because the private hospital sector was concerned to use its facilities for privately funded individuals rather than for

*Thousands of NHS beds have been closed or left empty – as private hospitals cash in on the pandemic*

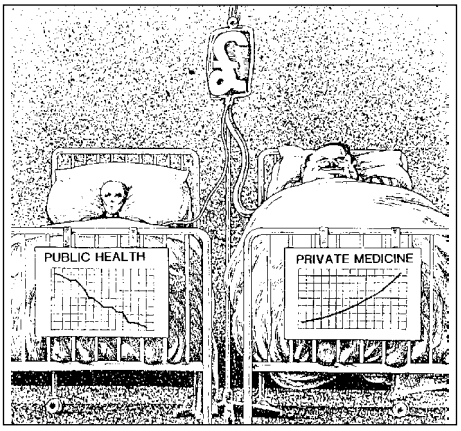
NHS funded patients because these are more profitable.

It was also keen to exploit the existence of large numbers of patients who had been unable to receive elective care (hip operations, cataracts, knee surgery etc) due to the fact that the NHS had become overwhelmed.

## Priority given to treating more profitable private patients rather than urgent NHS cases

In order to deliver these services to private patients, the private hospital sector could only do so if it used NHS consultants who were needed to respond to the pandemic.

In addition, whilst the private hospital sector was being asked to treat urgent NHS




cancer patients there were reports that it was refusing to do so at the price being offered by the NHS, instead preferring to treat less urgent and less complicated fee paying patients.

This resulted in NHS leaders asking their consultants not to dedicate their time to undertaking non-essential private work and to ask the private hospital sector to instead focus on treating urgent NHS funded patients.

The lack of control over private hospital facilities by the state in the midst of a pandemic and the extent to which the private hospital sector has benefitted from NHS subsidies raises serious concerns about the extent to which the current relationship is either value for money for the taxpayer and in the best interests of patients.

Previous governments have purchased private hospital companies which are in financial distress and incorporating them into the NHS rather than bailing them out and renting their facilities at high cost.

**For more information on private hospitals and Covid 19 visit *https://chpi.org.uk***

**80%**

**the percentage of its annual revenue which Australian owned private hospital company Ramsay UK generates from undertaking NHS operations**

**1 in 3**

**the share of NHS funded hip operations which took place in the private sector pre pandemic**

**£70million**

**the annual cost to the NHS of treating patients following post operative complications in private hospitals**

**£1.5 billion**

**the expenditure by the NHS in the private hospital sector over 12 months (pre-COVID)**

**£1 billion**

**the estimated expenditure by the NHS in the private hospital sector over 5 months during Wave 1 of the pandemic**

**£10 billion**

**the value of the contracts between the NHS and the private hospital sector over the next 4 years**

# Learning lessons on fighting privatisation from past & present

**By John Lister**

Campaigners have been fighting to prevent outsourcing and to keep and bring back services in-house since the first waves of competitive tendering were imposed by Margaret Thatcher's government to begin carving out slices of the NHS for private profit from 1984.

Privatisation of the NHS has always been a very different prospect from privatisation of utilities and nationalised industries, which always sold their services and products to customers, and in which shares were literally sold off, and the operation became a private company.

The NHS was from the outset conceived as a different type of service, to be available to all on the basis of need, and paid for collectively through taxation.

So since Thatcher's time, rather than selling it off, which would have raised public alarm at any time – and especially now that the Covid pandemic has reminded so many people of the value of an NHS which is provided as a service free to all at point of use – governments have gone down the route of **chopping off** services that could then be taken over by private providers (long term care for older patients) and **contracting out** chunks of the NHS to the **lowest tender**.

**The private contractors don't own the NHS or even the service they provide: but they are able to cash in on the security of public funding – and the public purse taking all the risks.**

This covert approach and the piecemeal localised contracting out of services has made it hard to build the level of public awareness that's needed for a broad, active campaign that makes a real impact on politicians and government. It has always been much easier to gather support for campaigns against tangible threats of cutbacks in local services than to mobilise to challenge the much less visible threat of privatisation.



## Some key principles from the earliest days are still valid today

**Workers**

As competitive tendering became a real issue the first focal point was the tenacious strike by outsourced women cleaners at Barking Hospital, whose dispute began almost at the same time as the miners' strike. Initial union campaigning focused quite understandably on the attacks on the pay packets, jobs and conditions of the staff.

**Preparing for resistance**

Resistance by the staff directly affected is also vital for the strongest campaign. Vague moans and defeatist groans won't convince others to mobilise to defend services against outsourcing.

So it is vital to raise the level of awareness amongst affected staff as soon as a threat becomes obvious.

Circulate information, use examples of contract failures elsewhere and the actions of specific companies to raise the alarm and prepare in advance of the crunch point: mobilised staff can put maximum pressure on hospital management before damaging decisions are taken.

It's always important to remember that while fighting back won't always win, deciding NOT to fight back guarantees you will lose.

**Community**

Both the miners' strike and the Barking Hospital strike quickly learned that the dispute is greatly strengthened by external community support – raising funds, but also raising the issue. To do this the miners developed increasingly wider arguments on the potential impact of pit closures on whole communities and areas: the campaigns and strikes against NHS privatisation also had to widen the scope of the dispute to win the broader support.

**Patients**

While it has always been important to emphasise fairness issues, the loyalty of in-house support staff to NHS, and their right to fair pay for jobs vital to the NHS, it soon

became obvious that successful campaigning needed to popularise the issue by also showing the impact of privatised cleaning and support on patients as well as staff – the threat of dirty wards, poorly laundered sheets, poor quality food, and the loss of friendly support staff to give moral support or offer a cup of tea.

**Target the private companies**

In a period of political polarisation for and against the Thatcher government, it was also important to exploit anger at what appeared to be corruption, and reveal the antics of the contractors.

We began to closely monitor and expose their track record, their dealings, their finances, their political connections, their contract failures, getting MPs and councillors to raise concerns at the companies moving in to take over local services.

**Management**

It was also important to keep the pressure on the hospital management and district health authorities (Trusts had not been set up in 1984) that were taking the decisions on whether or not to comply with pressure to privatise – supporting the stand of those that refused to do so, and singling out the most objectionable individuals driving local decisions to contract out.

Ganging up

The Contract Cleaning and maintenance Association, which groups some 41 contractors, has adopted a code of conduct in the tendering for health contracts, calling on all members forms to pay Whitley rates of hourly wages.

But there is no obligation whatever to provide the other conditions enjoyed by NHS staff — in particular sickness benefit and holiday pay. The main method so far of screwing profits from cleaning contracts has been through cutting back on the *number of hours worked* rather than the hourly rate of pay.

It appears that the contracting firms have agreed on the common line of paying NHS rates in an effort to regulate the in-fighting between themselves as each firm struggles for a larger share of the £400m cake on offer in the form of as many as 2,000 NHS cleaning contracts.

The larger, established contractors hope by keeping pay levels stable to make it more difficult for new, smaller outfits to undercut them. They also want the NHS to adopt an exclusive list of "approved" contractors — you've guessed it! All members of the CCMA!

In reality it seems likely that individual firms, under pressure to secure a slice of NHS business will begin to break ranks on pay — unleashing an ugly round of wage-cutting. In any event there seems little reason to believe that this particular gang of thieves will long honour their own agreements.

Stamp them out!

Following on from the same kind of abandonment of standards which comes with privatisation and exploiting the existence of a lucrative 'market' for quack remedies, Harley Street has long been infested with its own species of up-market cockroaches — the charlatans and con-men flogging sex-remedies and dubious cosmetic treatments to people with more money than sense.

But there is little point in the gutter press getting annoyed about the Harley Street rip-offs, which according to the Daily Express are now driving away wealthy Arab clients. The shysters are simply the logical end-product of present government policies which the Sun, the Mail and the Express so eagerly support.

The abuses of Harley Street — and the sick spectacle of medical care being dispensed only to those with the cash to afford it — could be brought to an end tomorrow. All it needs is a government prepared to nationalise the existing clinics and private foundations, and make private medicine illegal.

HARLEY STREET W1

Cockroaches angry at press reports

*Leaders of the Confederation of British Contract Cockroaches have strongly defended the Government's plans for privatisation.*

*Following an angry mass meeting of cockroaches in the grounds of Barking Hospital, staged to protest at 'biased' press coverage of cockroach activity on the wards, a statement was given to reporters stressing the contribution which these increasingly large insects are making to the cleaning efforts of the main contractors, Crothalls.*

*'Under previous governments, the private enterprise of Contract Cockroaches faced constant harassment.*

*'Now at last we are being given the chance in Barking to show what we can do when the bureaucratic red tape is cut loose. This government has finally given the small insect his head.*

*'The CBCC has for years argued that cockroaches have a role to play in cleaning up the morsels of rotting food and debris left behind by private contract cleaners, and at no extra cost to the taxpayer.*

*'Now, in close liaison with the scab workforce of Crothalls, we are showing in Barking Hospital the kind of insect-human cooperation which should be a model for the NHS. We are not simply feeding off the NHS; we are making a real contribution.*

*'Our services are increasingly appreciated by the less squeamish patients, some doctors and most DHA members.'*

*Brushing aside recent newspaper reports of a terrified mother sheltering her baby against an infestation of cockroaches, the CBCC representative hit back angrily at 'sensationalist' coverage.*

EXCLUSIVE! By our own correspondent.

*Citing statements by consultant bacteriologist Dr Robertson, who sits on Redbridge DHA, the CBCC spokesinsect challenged reporters to 'name a single disease which our members could give a baby simply by crawling over it.'*

*Accusing critics and the mother in question of being 'politically motivated', the cockroach leader insisted:*

*'Our members were merely checking the baby and its bed for edible morsels of rotting food. This is routine procedure for our Barking night shift.'*

*He went on:*

*'Our members do a dirty and sometimes hazardous job: we are now the mainstays of the hospital cleaning operation.*

*'Those who ignorantly criticise our work are simply arguing for the return of the bad old days of in-house NHS cleaning, when cockroaches were subjected to all manner of ill-treatment and denied a livelihood.'*

Cockroach leaders have rejected claims that they are opposed to the privatisation of NHS catering services, with the resulting decline in standards of food provided.

'There is no denying that the lower quality of the scraps left around for our members will be a problem,' said a representative of the Confederation of British Contract Cockroaches. 'But against that we must set the fact that larger quantities of food with be discarded uneaten, and kitchen facilities will be less thoroughly cleaned. My members are prepared to exchange quantity for quality.'

'The CBCC is still four-square behind privatisation and the contractors.'

'Cockroaches crawl on hospital babes'

*Summer 1984 – using an actual press report and humour to emphasise the threat to hygiene standards*

**Humour**

Use of cartoons, caricatures, humour and ridicule to expose the nonsensical logic of contracting out can make a powerful appeal.

In the 1980s with limited technology (no social media) we summed up the threat of contracting out with repeated use of leaflets, badges and printed publicity carrying images of, and references to, cockroaches and rats, exploiting every negative revelation and news story, every contract failure, and the instinctive fear of dirty hospitals to discredit the very idea of contractors cleaning hospitals.

**Evidence**

Then as now it has been important from the beginning to maintain a **consistent challenge** to the assumptions of the privatisers – using EVIDENCE to challenge bogus claims show the negative impact of cost-cutting on staffing levels in vital support roles, the safety implications, and the threat to the quality of labour intensive low-tech work such as cleaning.

**Catering** With hospital catering services also under threat campaigners worked with unions and experts to challenge the closing of hospital kitchens and switch to cook-chill and mass produced frozen food (which last year in Hinchingbrooke/North West Anglia we have found to be MORE EXPENSIVE per meal than freshly cooked food prepared on site).

**Short sighted savings**

The task was to find ways to publicise


and expose that the limited savings from privatisation were short sighted and ignored the costs, which became increasingly apparent during the 1980s – hospital acquired infections – including the proliferation of the then new "superbug" MRSA, infections meaning more patients stay longer in hospital (at greater cost): and warning that poor and unappetising food might be profitable for companies but led to slower recovery of patients, and poor morale of staff if served up to them as well.

**Breaking up NHS team**

It has always been important to emphasise that contracting out divides and weakens hospital teams – undermining the work of clinicians with poor hygiene, resulting in loss of control on the wards where the nursing staff and the cleaning staff wind up working for separate employers with separate line managers.

Another cost of privatisation is the loss of skills and experience of long-standing ward-based staff, and the support they were often able to give patients, as services and workforce have been broken up.

## More recent lessons

**More sophisticated**

Campaigns have become much more adept at mobilising public support for campaigns against outsourcing and re-tendering – drawing on instinctive sympathy for health workers and public concern for quality and safety of care.

Greater awareness and responsiveness to social and racial inequalities means that these issues too can and should be built in to campaigning.

**Squeeze out the profits**

Scottish unions were first to recognise that fighting to get privatised staff onto NHS pay would remove the profit from the contractor, or neutralise the cost advantage to the trust.

**Contractors denied long term prospect of profits may well pull out.**

Even where it's not possible to keep public services in-house, it's still worth fighting whenever services are outsourced to ensure that the resulting contract is as close as possible to NHS terms and conditions to minimise the damage to the living standards of transferred staff and maximise chances of contractors eventually pulling out.

**Benefits of in-house services**

It's important to highlight potential for service improvements from bringing services back in house – and underlining the high quality of services where management flirt


with contracting out to private providers. In January 2020 Imperial Healthcare Trust became the latest major trust to bring support services and 1,000 outsourced staff in-house, noting:

**"The move will help ensure our hotel services staff are able to play their full and fair role within our care teams and enable us to improve service quality collaboratively."**

**Forcing a re-think**

Last autumn in-house staff from the catering department, portering, logistics and linen services at Hinchingbrooke Hospital successfully forced a rethink by management of North West Anglia FT on plans to outsource these services, not least by writing to management and local politicians to emphasise that in-house staff had shown themselves to be loyal, flexible and committed to quality patient care through the peak of the Covid pandemic, in a way that could not be assumed from a private company.

**Splitting the ranks**

Solid local campaigning can split Tory politicians as we saw back in 2013 with a local MP leading a campaign to end the contract of the failing Clinicenta treatment centre in Stevenage run by Carillion – although the eventual deal wound up an expensive buy-out.

The local Tory MP in Harlow was also a useful additional voice to the 99% vote for six days of strike action in pressing the management of Princess Alexandra Hospital to scrap plans to transfer support staff into a "wholly owned subsidiary".

Last year's successful campaign against outsourcing at Hinchingbrooke Hospital also made strong use of pressure on councillors and MPs of all parties.

# Fighting the new privatisation

The post-Covid wave of privatisation poses some new problems.

While we now have access to powerful social media and electronic communications as additional weapons to mobilise and win support, we need to find ways to convince


a wider and in may ways uninformed public that privatisation threatens to undermine rather than reinforce the NHS services we know they love and respect.

## New services

The bulk of the contracting since the pandemic has been to staff brand new services rather than posing any threat to existing NHS staff – although the new mega-labs could prove to be a drain on staff in existing high quality NHS laboratories.

This means there is no existing body of NHS staff to mobilise and no obvious tangible threat, as most people see it, to the NHS.

However the long term damage of such huge additional spending flowing exclusively to private providers with only the most minimal and temporary support to NHS and social care providers must not be under-estimated.

## Shambolic failure

Campaigning to bring these services into the NHS and public health systems rather than remaining as a profit stream for Serco, Sitel and other companies therefore needs to base itself firmly on the proven shambolic failure and wasted resources inherent in the privatised system.

This is in shapr contrast to the calm expertise and extremely high success rate of the public health networks contact tracing and the NHS-run vaccination programme. **The private firms have proved again and again that there is heavy cost, but no advantage or expertise to be gained from contracting out.**

The shambles has reached the level that the test and trace system is beginning to be regarded as just as much a basket case as hospital cleaning rapidly became in the 1980s.

## Bring in to NHS

As the economy eventually re-starts many of the car parks and other venues for mass testing will in any case need to be replaced by NHS based testing Future testing centres.

So if the services are brought into NHS premises, there is a good argument for them to be provided by NHS staff on NHS terms and conditions – and with NHS taking responsibility for of standards of service.

## Laboratories

The new Lighthouse and mega laboratories, set up during the pandemic to run parallel to but barely connect with the NHS, must also be exposed as widely as possible as cutting standards, regulations, and recruiting staff to lower skill levels. The inevitable result is poorer quality and performance, waste and inefficiency – while undermining the existing NHS laboratories and pathology networks.

## Consultants

The hugely bloated numbers of dubiously useful and massively over-paid management consultants and their consistent failure to deliver the right answers for the NHS also need to be exposed and ridiculed, along with the NHS management who have become unhealthily dependent upon them..

## Investment

The billions spent so far and the £10 billion now committed over four years by NHS England to buying in services from private hospitals must also be a target.

While nobody wants any delay in cancer and other urgent treatment, and there might be a case for some specific short-term use of private capacity while the NHS struggles to deal with Covid cases, the longer term priority must be investment to bring the thousands of closed or unoccupied NHS beds back into full use.

For the NHS to be heavily dependent on private hospitals for front line capacity in four years time would be a major blow.

## Combined effort

**We need a combined effort of trade unions, campaigners, analysts and experts to work on the images, ideas, angles and arguments that can help to reach out to, convince and radicalise a wider movement.**

**We need a publicity campaign reaching into the NHS workforce and out into the wider public.**

**We need to fight for the billions that flowed so freely into private profits during the pandemic to be diverted into proper investment to rebuild and re-equip the NHS to cope with the post-Covid demands and pressures.**

# Campaigners offer a way forward to rescue our NHS

The **Rescue Plan** produced last July by Health Campaign Together – offering a **2020 vision for a post-Covid NHS** –sets out the background, cites the evidence, identifies the key issues and offers solutions.

It shows how slow the government was to act on the Covid disaster and how it failed to learn from its mistakes. It shows that years of inadequate funding and an ideology hostile to the public sector make things far worse than they could have been and will make recovery harder.

## Market failure

The failures of the market approach and outsourcing have been exposed again as contracts were offered to unsuitable contractors without any proper oversight – instead of simply expanding the proven public sector provision – for example around testing and PPE.

From the background and the evidence comes the challenge for this generation to find solutions on a scale reminiscent of the founding of the NHS.

Much in the suggestions for the Rescue Plan are already established. Nobody doubts the need for greater funding for the NHS and a truly massive programme for investment to rebuild lost capacity and to get the NHS fit for the future.

The scale of funding required is way beyond what the government is offering and the investment just to tackle backlog maintenance and essential changes due cope post Covid dwarfs what has been on offer so far. A New Deal it is not.

After the money the staff. Dealing with


the enormous staff challenges could start by giving them better pay and conditions and doing what is needed to encourage better training, recruitment and retention is obvious but again no sign of the government and its People Plan getting the message.

## Fragmented

Fragmentation due to Lansley's 2012 Health and Social Care Act was as bad as the campaigners predicted: things have got so bad that NHS management at all levels and even the Government were already ignoring the Act – and during the pandemic this became obvious to all.

The Plan calls for an end to the costly and bureaucratic commissioner/provider split as well as an end to competitive tendering and rolling back privatisation. Just how the transition can be made without another massively expensive and disruptive redisorganisation is an issue for genuine discussion.

## Democratic deficit

The Plan does however rightly point out the democratic deficit in the NHS, exemplified currently by the new non statutory "Integrated Care Systems," stressing that the NHS will need greater local accountability, not less.

Finally, despite being NHS focused the Plan also argues for reform of social care, although it does not map out any wider plan for wellbeing covering social care and other support services and benefits. However, the call for radical reform making social care closer to an NHS style model of universal, comprehensive care, free at the point of need is welcome.

At the heart of the social care debate is the whole question of the role for those who need care and support, a debate the NHS also needs to engage with – coproduction of health.

How should we move to a system of personalisation or integration around the person or whatever the terminology might be? Another huge area for debate which may also influence how the system is redesigned.

So a great start for a Vision – but still leaving lots of issues to discuss.

# Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an **alliance** of organisations. We ask organisations that want to support us to make a financial contribution to facilitate the future development of joint campaigning. **WE WELCOME SUPPORT FROM:**

- **TRADE UNION** organisations – whether they representing workers in or outside the NHS – at national, regional or local level
- local national NHS CAMPAIGNS opposing cuts & privatisation
- pressure groups defending specific services and the NHS,
- pensioners' organisations
- political parties – national, regional or local

The guideline scale of annual contributions we are seeking is:

- **£500** for a national trade union,
- **£300** for a smaller national, or regional trade union organisation
- **£50** minimum from other supporting organisations.

**NB If any of these amounts is an obstacle to supporting Health Campaigns Together, please contact us to discuss.**

**You can sign up online, and pay by card, bank transfer or by cheque – check it out at *https://healthcampaignstogether.com/joinus.php***