The lowdown

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

‘Mega lab’ not privatised, insists Department

A RESPONSE FROM the Department of Health & Social Care to local MP Matt Western has insisted that the new Leamington Spa “mega lab” is “publicly owned and operated,” despite staff being recruited by private companies Medacs and Sodexo.

However there is no claim that they will be NHS employees: Sodexo have been advertising jobs under ‘NHS Test and Trace’ and offering only fixed-term contracts, making no mention of NHS terms and conditions, NHS pensions, or UKAS accreditation. There has been no explanation of why the new lab could not be run, and staff employed, by the neighbouring University Hospital of Coventry and Warwickshire.

The DHSC statement also claims that “the new laboratory is being set up by leaders of science with decades of experience,” although this is clearly at variance with the issues raised by the Institute of Biomedical Science (IMBS) whose President Allan Hall told The Lowdown in January:

“It is a concern that instead of working with the professional bodies and the existing pathology community to explore how these new mass-testing labs could be staffed and run as extensions of the existing pathology labs, the government has chosen to engage with a recruitment agency [Medacs] with no pathology experience.

“It is vital that these labs have an appropriate skill mix and include significant numbers of HCPC [Health and Care Professions Council] registered biomedical and clinical scientists. We would not allow unregistered staff to run care in clinical settings such as medicine, nursing or radiography – why are labs being viewed as ‘different’?”

The new lab will run 24/7 and employ 1,800 full-time staff, but there are apparently no jobs advertised for biomedical scientists.

Local campaigners fear that the lab might offer higher hourly rates, aiming to poach NHS professionals from NHS trusts in the region – although any staff who left the NHS to work there would give up their NHS pensions, sick pay, holidays, training and permanent contracts.

A campaign is needed to recruit the staff into trade unions and to secure NHS terms and conditions.

John Lister

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Frimley drops subco plan: another one bites the dust

THE WELCOME NEWS has leaked out that Frimley Health is not going to go ahead with any further work on setting up a Wholly Owned Subsidiary (WoC). Two years of effort by the trade unions have again paid off and staff will not be transferred out of the NHS against their will.

I have worked for Unison on more than 20 proposals for various WoCs across the country over the last five years. It is worth reflecting on some of the lessons.

The Frimley proposals were running in parallel with those at Bradford. Both had been through the NHS Improvement process for validation and astonishingly Bradford had "passed". For Bradford this did not count for much, as after some intense round-the-table exchanges – ending with a face-to-face meeting with the chief executive and chair – the proposal was dropped.

Frimley proved harder to deal with, and the initial intransigence of management was met by a very solid ballot for industrial action. Intensive talks involving the three main trade unions then took place over several months as the unions were presented with the management case and demolished it. Unison, Unite and the GMB worked very well as a team. Then the pandemic focused minds elsewhere and nothing progressed for a year – now it is over.

Lack of staff involvement

There is a pattern to most of these sagas. Proposals are developed in secret with no staff involvement; proposals reach the stage of planning for implementation and discussions are offered on how to make the change, not on why the change is needed. Staff are presented with limited information which is highly biased and requests for more information are brushed aside – it is all too complicated for staff representatives to comprehend. Staff are told all will be well, and claims are made that talks with staff have had a generally positive response. Additional information is offered to address fears that have been expressed and to dismiss them.

But from here on it gets harder, as now the trade unions have to be involved. They do not want to discuss how things are to be done: they want talks about why they need to be done in this way. They ask for the case to be made to them. Despite quite clear guidance management routinely refuse to disclose their business case claiming commercial confidentiality – entirely bogus, as most business cases are very poor!

Details do get out: and it is almost inevitable that the management case collapses. Proper options appraisals are rarely carried out – working with staff representatives to address whatever the problem is, then developing and investing in the current workforce to get a consensus solution never gets a look in.

If options are evaluated at all then this is done by management teams, not those who know the work. So cases fall apart as the unions input their real world experience.

There are usually two things to look out for alongside weak business cases. Too often proposals are led by external management consultants working full time on them and this is a problem – they are biased, as their income depends on their ideas going ahead – they really hate being challenged!

Conflicts of interest?

And too often, these projects are led by a member of the executive team who stands to gain an increased role or a promotion if it goes ahead – maybe being the chief executive of the WoC. Rarely do boards challenge the advantages put to them.

Experience does show the value of being able to challenge the case objectively and robustly – often board members only hear the positives from those driving projects and are amazed when the unions point out some of the issues.

But campaigning helps too. In a few places there have been particularly stubborn managers leading the charge. So, negotiations are supported by the threat of industrial action, by press and social media campaigns, and even sometimes by demonstrations to force negotiations to be taken seriously.

Another one bites the dust: this time one of the flagships being pushed by NHS England/Improvement. Hopefully, this is the last time, as likely tax changes and an even tighter oversight of proposals – combined with the excellent record of the unions in opposing proposals, will kill off any other attempts.

Richard Bourne

Bleak prospects for troubled ICSs

EVEN BEFORE they gain any statutory powers some Integrated Care Systems (ICSs) are facing major problems, while others are concealing them by not fully revealing the state of play.

There are problems ahead in areas where ICSs straddle the boundaries of local authorities. The White Paper proposes ICSs should be coterminous with local authorities but, as the HSJ points out, almost 20 ICSs potentially breach this requirement – from Cumbria and North Yorkshire in the north through to Essex, Surrey and Hampshire in the home counties.

In some areas councillors and MPs are kicking off about it. One Essex Tory has warned that: "We have an intense backlog in cancer and mental health and instead of talking about how to restart and reboot the system, we are going to spend 18 months having to pull apart the [memorandum of understanding] that took 18 months to sign. I think this is [a] retrograde step."

Local resistance

In Cheshire, Tory councillors are bitterly complaining at their health commissioners being merged with Merseyside, fearing Liverpool will call the shots. Meanwhile in Bedford, Luton and Milton Keynes, a pioneer ICS, management consultancy Carnall Farrar has warned there is little harmony between the 'partners': "Senior relationships are poor and there is a lack of trust in the system. Relationships consistently emerge as a barrier and are strained by unclear accountability and authority…"

The improbably-named "Together We're Better" ICS covering Staffordshire and Stoke on Trent boasts about having secured support from the local medical committees for the CCG merger, having beaten down the strong opposition from GPs in five of the six CCGs: but shadow board papers warn that "priorities will be reflective of the financial challenge across the system".

In Nottingham and Nottinghamshire ICS, one of the few with serious board meetings and papers, there are also big financial worries about hitting tough targets.

But the biggest nightmare of all is tucked away in the board papers of the Lancashire and South Cumbria ICS, which reveal the scale of the financial problems lying in wait as it gets ready to operate a single system-wide "pot" of funding. A 3 February update on longer term financial challenges begins with a far from distant mega-gap in funding: "… all in all the implication of the guidance is that L&SC could be in deficit somewhere within a range of £240m to £340m (depending on how much NR [non-recurrent] money may be made available). The Board may recall that in February 2020 the assessment was of a deficit of £277m which, when taken together with the 23 December NHSEI letter, leads me to advise that the gap could be at around the £300m mark."

This is equivalent to 8% of the ICS's £3.7bn budget: to clear it even over a period of time would require far-reaching cuts in provision of services. Even NHS England has recognised that such huge sums cannot be saved straight away, if at all: the "control total" target prior to Covid called for a reduction in the deficit by a staggering £180m, from £277m to £97m.

The report sums up: "A £300m deficit reduced to zero over three years = £100m (2.7%) savings a year and over 5 years = £60m (1.6%) per annum. L&SC has never managed an absolute reduction in the amount spent on health services. These facts illustrate the huge challenge facing our system."

Perhaps even more ominous are the options being discussed for cost-cutting. According to the "RightCare" model there are "opportunities" for reductions in spending on Musculoskeletal (£25m), Circulatory diseases (£24m), Respiratory diseases (£14m), Same day emergency care (£14m), Neurology (£13m), ambulances (£13m) and even rauma and injuries (£10m) – totalling £113m. According to the "Model Hospital" £154m could be saved from overlapping cuts in spending on Obstetrics and Gynaecology (£27m) Emergency medicine (21m) Cardiology (£16m) General medicine (£12m) Orthopaedic and spinal (£11m) and an obvious larger but lower-profile target of non-clinical services ('back office, estates, etc.') (£67m).

More cuts to come

Even if they could make half the £300m savings target from these, it would still leave another £150m in painful cuts to come. This is the grim new world of ICS financial discipline.

Let's remember Lancashire and South Cumbria was the ICS where the director of finance and investment openly stated back in 2019 that he wanted the ICS in place so he could push through "tricky" decisions: "The place we need to get to is where we can enforce decisions on a majority basis."

** The next Lowdown will examine the latest round of new hospital and reconfiguration projects, including the debates over new hospital or hospitals in Lancashire and South Cumbria, Gloucestershire, Leicestershire, East Kent and Sunderland.*

Waiting lists during the pandemic: from 'zero tolerance' to looming crisis

THE PHRASE 'incomplete pathways' – NHS-speak for waiting lists – didn't feature in the four-step roadmap offered up by the prime minister two months ago, but it represents a major roadblock on his 'route back to a normal way of life', one which will take years to clear.

Earlier this year the centre-right thinktank Reform warned that waiting lists for hospital treatment could more than double by April and soon hit ten million in England alone. It claimed that six million fewer patients were referred to treatment in 2020 than in 2019, and that cancellations of diagnostic testing and delayed treatment may lead to more than 1,660 extra deaths from lung cancer alone.

Year-on-year data for January and February, released this month by the British Medical Association (BMA), shows the extent of this rapidly growing problem:

- the number of patients waiting more than 12 months rose 185-fold, from 1,643 to 304,044, the worst performance against this target since it was set in 2008 (NHS England actually introduced a zero tolerance of waits of more than 52 weeks in 2013-14)
- there were three million fewer elective procedures and almost 21 million fewer outpatient attendances
- the elective treatment waiting list increased to 4.59 million, a likely under-representation of the total, due to a drop in referrals since March last year
- just more than 66 per cent of patients were treated within 18 weeks, down from 83.5 per cent in January last year (the NHS England standard, introduced in 2012, is 92 per cent)
- just 139,378 patients were admitted to a bed for consultant-led treatment, down 54 per cent on the January 2020 figure of 304,888
- the NHS England target of treating 85 per cent of cancer patients within two months of an urgent GP referral was missed again (the target has not been met for more than five years)

In its latest report on waiting times, the King's Fund thinktank (echoing information from an earlier NHS annual report) reinforces the idea that the problems experienced by the health service are historic, as well as being driven by the pandemic:

- the four-hour waiting time standard for A&E services hasn't been met since July 2015 (but it was still a shock to hear a Royal College of Emergency Medicine spokesperson tell the BBC that the number of hours ambulances spent waiting to offload patients in some parts of England was "off the scale" in January this year)
- the 18-week waiting time standard for planned elective care hasn't been met since February 2016
- by December there were more than 220,000 patients waiting more than a year for routine planned care, compared to only 1,500 people in December 2019

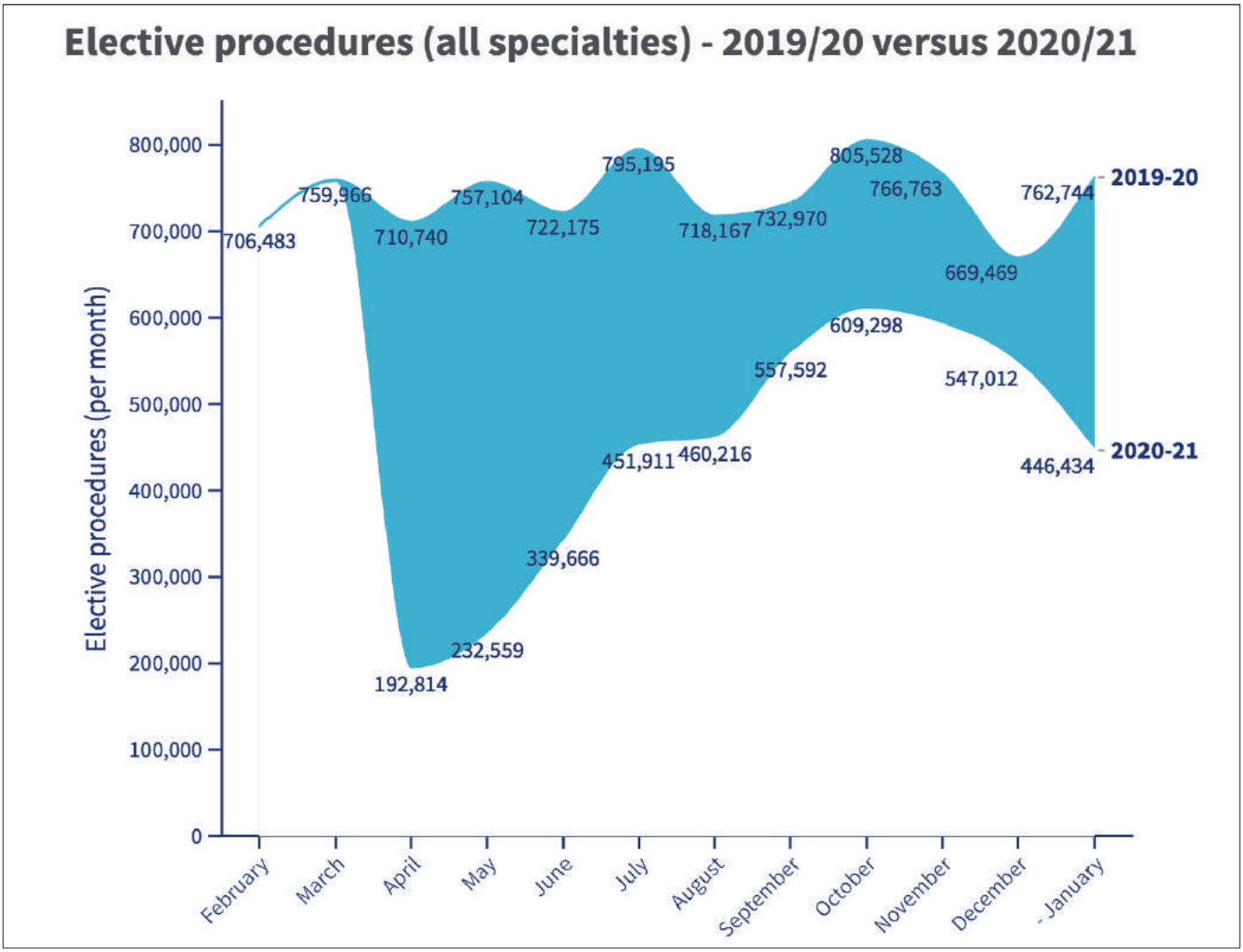
Backlogs pre-date the pandemic

Looking in more detail, the online news site HSJ analysed provisional data from NHS England on various health sectors recently and found that ophthalmology patients had been particularly badly hit by the knock-on effects of the pandemic on surgical capacity. The number of patients waiting 52 weeks or longer for ophthalmology treatment (mostly for cataract surgery) had increased to more than 23,000 in December – up 57,580 per cent (just 40 patients) on the year before.

Waiting lists like these – and the impact they have on patient outcomes – have obviously been made worse by the pandemic, but their origins pre-date it by at least a decade, and their impact, following years of under-investment in the NHS, was clearly evident in the months leading up to the first lockdown.

In March 2019 the number of patients waiting to start planned, consultant-led hospital treatment was 4.23 million, up 10 per cent on the same period a year earlier.

Just before the 2019 general election the Health Foundation published a list of priorities for whichever party would end up in Number 10, and it chose to highlight that England then had: the highest proportion of people waiting more than four hours in A&E departments since 2004, the highest proportion of people waiting more than 18 weeks for non-urgent (but essential) hospital treatment since 2008, and the worst performance against waiting times targets since those targets were set. It also called for more staff and investment in the NHS and social care, to help reverse lengthening waiting lists.



Source: NHS Digital/Flourish

And a few months later, just weeks before the first lockdown, the charity Brain Tumour Research shone a spotlight on NHS England statistics showing that 64 per cent of hospital trusts had missed cancer waiting times – with 2019 being the worst year since the targets were introduced – and that the number of those who had to wait longer than two weeks for a first appointment with a consultant after an urgent cancer referral from a GP increased by 30 per cent, up 50,000 from 2018.

More cash needed to ease the pressure

Chancellor Rishi Sunak's decision not to award the NHS any extra cash in last month's budget to help it cope with the pandemic came as a shock to many, and has only been partially offset by health secretary Matt Hancock's subsequent award of an additional £6.6bn a few days ago. This figure was considerably less than the £8bn sought by NHS England chief executive Sir Simon Stevens when he addressed MPs in early March, and may have little impact on waiting list pressures.

As the King's Fund acknowledged last month, extra funding made available by the chancellor last year to procure extra capacity from the private sector may go some way to relieving waiting lists, but the scale of the backlog means that it will still "take several years before access standards are routinely met again".

That's an outlook shared by the Royal College of Ophthalmologist's Melanie Hingorani – who told HSJ that clearing the ophthalmology treatment backlog could take more than two years, adding, "And maybe we [will] never catch up" – and also by one un-named acute trust boss quoted by the Guardian this month, who said, "I think [the backlog in cancer and heart disease surgery] will take many years. How long? Who knows?"

Similarly blunt assessments no doubt informed the call last July by the Royal College of Surgeons for a "plan for recovery" to address the "bomb" that had "already detonated" under surgical waiting lists. Sadly, eight months later, the government has yet to seriously engage with this urgent challenge.

Martin Shelley

Sugar tax is a win-win

THE INTRODUCTION of taxes on soft drinks high in sugar has been found to be an effective way to make manufacturers reformulate their products, which has led to a reduction in sugar consumption, according to a study published in the BMJ.

The SDIL, unveiled in the budget of March 2016 by the then chancellor George Osborne and enacted in April 2018, applies a tier tax on soft drinks with 5 or more grams of sugar per 100 millilitres. The levy increased the price of high-sugar soft drinks in an effort to reduce sales of these products, but also aimed to get manufacturers to reformulate their products to reduce their sugar content. And the study published in the BMJ found that within a year of the SDIL introduction this is exactly what happened; to avoid price hikes, the drinks industry reformulated their products to reduce the sugar content.

The study in the BMJ found that one year after the implementation of the SDIL, sugar purchased as part of soft drinks to be consumed at home fell by 30g per household per week. There was, however, no significant change in the volume of drink purchased. This meant that consumers drank less sugar, but the industry's bottom line was unaffected.

Prior to the SDIL introduction, researchers had modelled its likely effect on sugar consumption and considered that the tax could be expected to lead to a decrease in sugar consumption from these drinks in the range 7-38 g per person per week, which would be associated with a reduction in the number of obese individuals in the UK of 0.2-0.9%. The reduction in sugar consumption of 30g per person per week found in the real-life study was in the range predicted.

The excess consumption of free sugar is known to be a major contributor to diet related diseases, including tooth decay, type 2 diabetes, obesity, and cardiovascular disease. Now, however, there is also strong evidence that mortality from Covid-19 disease is far higher in people who are obese. A recent report from the World Obesity Federation found that Covid-19 death rates are 10 times higher in countries where more than half of the adult population is classified as overweight.

Perfect target for action

As the free sugar in soft drinks has no nutritional benefit whatsoever, soft drinks have long been considered a perfect target for public health action of this kind. But it is also possible to introduce some type of levy on other food groups high in sugar, fat and salt.

Such a levy was recommended back in 2015 in a report from Public Health England (PHE), called Sugar Reduction: the Evidence for Action, which set out a range of tough policies that it said needed to be implemented to reduce the consumption of sugary foods and drinks fuelling the obesity crisis.

Its recommendations were almost completely ignored by the Conservative government then led by David Cameron. The Guardian at the time reported that Cameron did not even read the report before dismissing the idea of a tax on sugary foods.

The report recommended the introduction of a price increase

of a minimum of 10%-20% on high-sugar products through the use of a tax or levy such as on full-sugar soft drinks. The only action from this report that made it into law was the SDIL; reformulation of foods to reduce sugar, fat and salt in other food groups was encouraged but was entirely voluntary.

The findings from the study on the SDIL are important for two reasons: it shows the success of a mandatory approach, which targets the profits of the manufacturers, but also shows that such approaches do not inevitably lead to a reduction in sales and therefore profits for the manufacturers.

An editorial in the BMJ notes that it is unsurprising that "embedding profit motives in regulation is an effective way to shift the behaviour of profit driven enterprises."

The SDIL has brought about "widespread reformulation with potential benefits to population health, even without reliance on consumer behaviour change."

Positive outcome

There was strong lobbying against the SDIL at the time by industry bodies, including the Food and Drink Federation, and individual companies. They thought that the levy would have little effect on consumer behaviour and have no impact on obesity.

Looking at the study it appears that consumer behaviour has not in fact changed, volumes remain the same, but the SDIL has forced manufacturers to actually reformulate their products leading to a positive public health outcome.

In contrast, Public Health England's attempts to get food companies to cut salt and sugar in other products voluntarily have largely failed.

The government's sugar reduction programme, a voluntary scheme for manufacturers introduced in 2015, aimed for a 20% reduction in sugar by 2020 for eight categories of foods, including breakfast cereals, yoghurts, puddings, biscuits, and cakes. The latest available assessment of the period 2015 to 2018 found that the overall reduction in sugar per 100g was just 2.9% by 2018; it was highly unlikely that it would reach its target of 20% by 2020. There were also considerable differences between food categories – yoghurt/fromage frais were down 10.3% and breakfast cereals down 8.5%, but sugar in puddings and sweet confectionery was actually up 0.5% and 0.6%, respectively.

Looking at the poor performance of the voluntary approach, the success of the mandatory SDIL, which was known before the publication of the paper in the BMJ, and the new information on the effect of obesity on mortality in Covid-19 disease, it was concerning and surprising that the UK government's new obesity strategy unveiled in July 2020 *(see box)* contained no plans for a similar levy for foods high in sugar, fat and salt. Indeed, with the exception of the ban on TV and online adverts for high fat, sugar and salt food before 9pm and some restrictions on food promotions, the strategy, together with the related Better Health strategy, relies heavily on individuals making choices and taking responsibility. Manufacturers appear to have been given a free pass.

OBESITY STRATEGY RECOMMENDATIONS – JULY 2020

- ***Ban on TV and online adverts for food high in fat, sugar and salt before 9pm***
- ***End of deals like 'buy one get one free' on unhealthy food high in salt, sugar and fat***
- ***Calories to be displayed on menus to help people make healthier choices when eating out – while alcoholic drinks could soon have to list hidden 'liquid calories'***
- ***New Better Health campaign to help people lose weight, get active and eat better after covid 'wake-up call'***

Indeed, critics (from both sides of the debate – food manufacturers and public health) were quick to point out that the strategy relies on tired outdated ideas.

In an editorial on the obesity strategy in the BMJ, Christina Marriott, chief executive of the Royal Society for Public Health, said:

"Simply passing the buck to the individual with another healthy eating campaign will not turn the tide on this silent epidemic . . . Unless the government has the courage to stand up to industry where it matters—taxing unhealthy foods and restricting the relentless bombardment of junk food and its advertising—we are concerned that the new plans will be another wasted opportunity.

Levy needs to be extended

An editorial in Nature Reviews Endocrinology noted that the obesity strategy document does not address the complex underlying causes of obesity; the genetic, environmental and socioeconomic factors that are involved.

In fact, the strategy perpetuates the message that simply eating less and moving more will solve obesity and the "choice of language could be damaging as it encourages the blaming and shaming of people with overweight and obesity."

Faced with overwhelming evidence from the SDIL that industry can rise to the challenge of reformulation if its profits are on the line, it surely makes sense to extend the levy to other food groups high in fat, sugar and salt. Now that the NHS is under such extreme pressure and the link between Covid-19 deaths and obesity is obvious, it seems almost farcical that the government is yet again taking an approach that blames individuals for their poor choices and lack of responsibility, and ignores environmental and socioeconomic factors, whilst completely ignoring an approach, the SDIL, that has been found to be effective.

The dying days of local NHS accountability

BELIEVE IT OR NOT, we are in the last days of relative transparency and local accountability in England's NHS. It has seemed profoundly unsatisfactory up to now, but if ministers get their way we will soon see how much worse it can get..

It's all set to change with the imposition right across the country of so-called "integrated care systems" (ICSs) – to be followed up by new legislation that will establish them on a statutory basis. The government proposals for this legislation, outlined in the recent White Paper, would also scrap the remaining Clinical Commissioning Groups, but also abolish some of the key powers of local authorities (dating back to the 1970s) to hold NHS bosses to account and challenge controversial hospital closures and reconfigurations.

"Of the first 29 ICSs, over two thirds still give no public information about board meetings or publish any papers"

These changes will make it harder than ever for health workers or the local public to find out what's going on at local level, and for local communities to challenge or lobby for changes from ever-more remote NHS management.

From 1 April many if not all of the remaining 100-plus as-yet unmerged CCGs will be merged to form the basis of just 42 Integrated Care Systems.

In Cheshire this means that the county-wide CCG, only established last April, will be scrapped after a year of inconclusive life, and merged with Merseyside – despite the opposition of the county's Tory councillors who fear it will fall under the thumb of the Liverpool City Region.

Doing outrageous things

The transition from CCG to ICS is not just a question of much less locally based bodies taking decisions and reduced local accountability: CCGs (after an uncertain start in 2013) have operated as public bodies, with their governing body meetings held in public and most of their board papers published: they are subject to the Freedom of Information Act.

This of course has not stopped CCGs doing outrageous things, energetically complying with the 2012 Health and Social Care Act that requires them to put a growing range of services out to competitive tender, eagerly handing out contracts to dodgy private companies, spending millions paying management consultants to draw up savage plans for "centralisation" and reorganisation of hospital services, drawing up growing lists of services no longer available on the NHS, and blanking local politicians and communities seeking to challenge them.

However as they stand most of the ICSs that are to replace them are not, and do not aspire to be, public bodies, or accountable other than upwards to NHS England and the Health Secretary, who would gain new powers to intervene and to veto appointments of top management under the government's proposals.

Most of them have little or no public profile or activity, and little more than neglected, often purely superficial websites. Local communities that do not know what NHS leaders are discussing or planning and have no responsible body they can lobby to

have their problems addressed are disempowered communities – and all the talk in the world about "engagement" will not alter this.

The Lowdown has been periodically checking for any signs of genuine life in the first rounds of ICSs to be approved by NHS England – but in most areas we have found little or none. Our latest survey in March 2021 shows little if any change.

Of the first 29 ICSs, over two thirds (20) still give no public information about Board meetings or publish any papers. Many have still published nothing of note since the Sustainability and Transformation Plans (STPs) of 2016.

Of the 13 STP areas in which unmerged CCGs will be merged and shadow ICSs launch in a few days time, more than three quarters (10) also lack any evidence of the establishment or plans for an ICS Board to meet in public, and have published no plans or papers indicating how they intend to proceed. Herefordshire & Worcestershire, for example boasts a "charter" on integrated care that promises:

"We will work together at pace to challenge ourselves and each other to deliver our aims. We expect to make real progress in 2018."

Of course the Covid pandemic has clearly diverted attention away from 'transformation' and reorganisation of services: Kent & Medway for example, where the merged CCG in January ranked preparation for an ICS as only its FIFTH priority, noted on their website that:

"As the majority of our workforce is supporting the NHS in Kent & Medway's response to Covid-19, transformational work led by the Kent and Medway STP is on hold. During this time, we will not be updating this website."

Lack of transparency

However the work being "on hold" has not stopped Kent & Medway pressing ahead for ICS status this month.

Of course the logical response to the restricted scope for discussion and reorganisation during the pandemic would be to at least postpone the far-reaching changes that threaten for a second time in a decade to abolish the existing local structures running the NHS.

Instead up and down the country the same old trite formulae are trotted out, or nothing at all is said; either way the public and health staff are left in the dark as the deadline for CCG mergers and ICS formation looms closer.

"The ICSs are not really integrated, they don't care, and it's clear many are not even systems"

Cambridgeshire and Peterborough might appear to be an exception, with their bold declaration that "Although the STP Board is not a statutory NHS body we want to ensure openness and accountability to the public in the business of the Board and, therefore, our meetings will operate in a similar manner to Statutory NHS body Boards."

However the emptiness of this is revealed in the decision last November that "To support the creation of the ICS, a consistent and compelling approach to communications and engagement is required."

The Board agreed five "key communications priorities for the next six months," including production of an ICS website "in partnership with CUHFT (whose web platform we plan to utilise to maximise return on investment and minimise costs)" and a monthly newsletter.

A "Band 7 individual" was to be recruited "on a temporary basis for six months" to help support the production of materials/ content, "working under the guidance and management of the Head of Communications and Marketing at the CCG and System Governance/Business Manager."

None of this appears to have happened. There is no website.

Whatever is being done to prepare or advance the work of ICSs is being done behind firmly closed doors and with no public information or scrutiny.

Nor is there any real integration. Despite all the warm words, local government remains firmly on the fringes of decision making even if they are involved at all – and the proposed legislation to give ICSs statutory powers would also strip away existing powers from elected local politicians.

As a consolation prize the White Paper offers councillors the prospect of running subordinate "Partnership Boards" that would be open to all and sundry – including private companies – although what influence they may have is open to doubt.

As we have warned, the ICSs are not really integrated, they don't care, and it's clear many are not even systems: the one definite change they bring is far less accountability to local communities – and more to Matt Hancock..

John Lister

How do GPs fit into the NHS?

THE SALE of AT Medics to the US company Centene in February this year and the more recent reference by Matt Hancock to GPs as 'private companies' has thrown a spotlight on GPs and how they operate within the NHS..

Matt Hancock, whilst giving evidence to the House of Commons health and social care select committee, said the success of the Covid-19 vaccination campaign was down to the amazing work of 'private companies', such as GPs and pharmacies.

The BMA GP committee chair Dr Richard Vautrey told GPonline that this characterisation of GPs as private companies was a "gross and deliberate misinterpretation."

He added:

'GP practices are independent contractors…..and there is a clear distinction between independent contractor organisations purely set up to deliver NHS services and who are commissioned solely by the NHS, and truly private commercial providers which are businesses set up to provide health services and which would, and do, exist with or without the NHS commissioning them."

Some mainstream media have also recently resurrected their articles about GPs earning vast amounts of money.

So how do GPs fit into the NHS?

The system of General Practitioners (GPs) and primary care is the cornerstone of the NHS. They are the first point of contact for anyone with a physical or mental health need and either treat patients or refer them on to the appropriate pathway for diagnosis and treatment. They are also involved in the prevention of illness.

When the NHS was formed in 1948, for various reasons GPs were not brought into the NHS in the same way hospital doctors were, but remained as independent contractors.

Over time, however, GPs and the primary care system they head has become embedded within the NHS. So despite being independent contractors, they were to all intents and purposes NHS employees.

Most GP practices are operated by a partnership of two or more GPs. The GP or GP partners are contracted to the NHS to provide primary care services. The GP partners are responsible for employing other staff to provide services, such as salaried GPs, nurses, and other healthcare-associated staff, a practice manager and administration staff.

What contracts do GPs hold?

The contracts held by GP partners set out mandatory requirements and services for all general practices, as well as making provisions for several types of other services that practices may also provide. The majority of GP partners contract with the NHS using the General Medical Services (GMS) contract.

The GMS contract is the national standard GP contract, which is used by around 70 percent of GP practices. The contract is negotiated every year between NHS England and the General Practice Committee of the BMA, the trade union representative of GPs in England.

There is a slightly different version of the GMS, known as the Personal Medical Services (PMS) contract. It was negotiated between a general practice or practices and the local CCG or NHS England and was designed to be more flexible so that the GPs could address local needs more accurately. This is being phased out, however.

In 2004, a new type of contract was introduced for the provision of NHS primary care; theAlternative Provider of Medical Services (APMS) contract. The APMS contract allows the contract to be held by a private company or not-for-profit organisation; the contract no longer has to be between a named GP or GP partners and the NHS.

The APMS contract effectively opened up primary care to private companies owned by directors/shareholders. Rather than GP partners who had worked in the area for years, primary care could instead be provided by a private company employing salaried GPs. Private companies with backing from investors were often in a strong position to win several APMS contracts.

How are GPs paid in a GMS/PMS contract?

A GP surgery that holds a GMS or PMS contract is paid for services provided – mandatory services, additional and out-of-hours services where they have been agreed – plus income from other NHS sources such as the Quality and Outcomes Framework scheme or payments for providing enhanced services.

At least half of a practice's income is based on a formula that bases the income on the make-up of the practice list, the population the practice serves, and takes into account age and gender. The money is usually paid to the practice not an individual GP.

Out of this income the practice must pay all its salaried employees – GPs that are not partners, nurses, admin staff etc., plus the cost of running the premises – only after all these deductions do the GP partners get paid, usually based on sessions each GP has worked. So the GP partners do not get a salary, but get paid dependent on practice income. It is important to note that partners in GP practices are also personally liable for any losses made by the practice.

How are GPs paid under APMS contracts?

The introduction of the APMS contract radically changed this whole pattern of payment. GPs employed by companies that hold APMS contracts are salaried, unless they are directors of the company.

APMS contracts are advertised with a fixed amount of payment over what is usually a ten year contract term. The contract holder then decides how the money is spent. As long as mandatory services and any additional services in the contract are covered, plus quality is preserved, then any money not spent is essentially profit for the company holding the contract.

If a company or organisation holds several APMS contracts, then economies of scale come into play and methods to reduce costs such as downsizing and downskilling the workforce, increases the profits that are made.

Because of the structure of the fixed-price contract, these companies can take the profit out of the surgery contract (and out of the NHS) to pay directors large salaries plus dividends to shareholders. The structure of these contracts means that the NHS does not gain if efficiencies and savings are made, they only increase the profits taken by the company.

It is easy to see how in some cases GPs who are also directors of the companies that own many APMS contracts can make vast amounts of money, way beyond what the average GP partner with a GMS contract makes.

It is important to distinguish between the two different types of contract when referring to GPs as the private sector. The vast majority of GPs in this country are independent contractors that work solely under contract for the NHS.

However, due to the presence of the APMS contract, private companies that have a variety of healthcare interests, including outside the NHS, have begun to take over primary care..

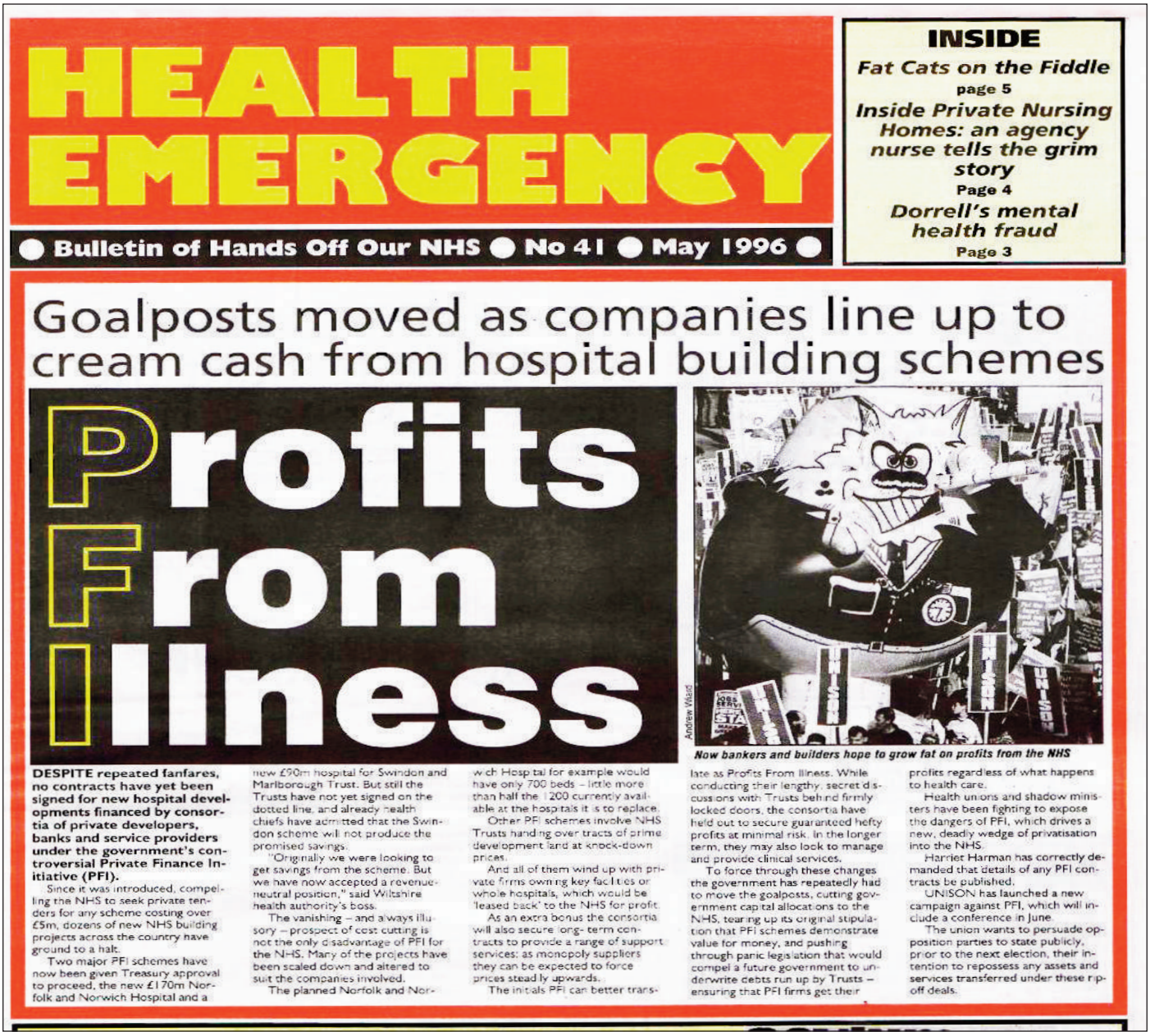
Sylvia Davidson

A history of privatisation part 4: the early days of PFI

THE PRIVATE FINANCE INITIATIVE (PFI) began life in November 1992, two years after the enforced departure of Margaret Thatcher, and just months after John Major stunned the country by winning a surprise Tory election victory over the Labour Party led by Neil Kinnock.

Chancellor Norman Lamont delivered an Autumn Statement which announced: "…the Government have too often in the past treated proposed projects as either wholly private or wholly public. In future, the Government will actively encourage joint ventures with the private sector, where these involve a sensible transfer of risk to the private sector."

Up to then the Tories had shown little interest in investment in public sector infrastructure, and focused instead upon controlling "public spending in general and capital spending in particu-



HEALTH EMERGENCY

Bulletin of Hands Off Our NHS ● No 41 ● May 1996

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Goalposts moved as companies line up to cream cash from hospital building schemes

Profits From Illness

Andrew Wald

Now bankers and builders hope to grow fat on profits from the NHS

DESPITE repeated fanfares, no contracts have yet been signed for new hospital developments financed by consortia of private developers, banks and service providers under the government's controversial Private Finance Initiative (PFI).

Since it was introduced, compelling the NHS to seek private tenders for any scheme costing over £5m, dozens of new NHS building projects across the country have ground to a halt.

Two major PFI schemes have now been given Treasury approval to proceed, the new £170m Norfolk and Norwich Hospital and a new £90m hospital for Swindon and Marlborough Trust. But still the Trusts have not yet signed on the dotted line, and already health chiefs have admitted that the Swindon scheme will not produce the promised savings.

"Originally we were looking to get savings from the scheme. But we have now accepted a revenue-neutral position," said Wiltshire health authority's boss.

The vanishing – and always illusory – prospect of cost cutting is not the only disadvantage of PFI for the NHS. Many of the projects have been scaled down and altered to suit the companies involved.

The planned Norfolk and Norwich Hospital for example would have only 700 beds – little more than half the 1200 currently available at the hospitals it is to replace.

Other PFI schemes involve NHS Trusts handing over tracts of prime development land at knock-down prices.

And all of them wind up with private firms owning key facilities or whole hospitals, which would be 'leased back' to the NHS for profit.

As an extra bonus the consortia will also secure long- term contracts to provide a range of support services: as monopoly suppliers they can be expected to force prices steadily upwards.

The initials PFI can better translate as Profits From Illness. While conducting their lengthy, secret discussions with Trusts behind firmly locked doors, the consortia have held out to secure guaranteed hefty profits at minimal risk. In the longer term, they may also look to manage and provide clinical services.

To force through these changes the government has repeatedly had to move the goalposts, cutting government capital allocations to the NHS, tearing up its original stipulation that PFI schemes demonstrate value for money, and pushing through panic legislation that would compel a future government to underwrite debts run up by Trusts – ensuring that PFI firms get their profits regardless of what happens to health care.

Health unions and shadow ministers have been fighting to expose the dangers of PFI, which drives a new, deadly wedge of privatisation into the NHS.

Harriet Harman has correctly demanded that details of any PFI contracts be published.

UNISON has launched a new campaign against PFI, which will include a conference in June.

The union wants to persuade opposition parties to state publicly, prior to the next election, their intention to repossess any assets and services transferred under these rip-off deals.

lar". Successive Labour Chancellors had also dutifully followed the advice of the Treasury, and seen it as their role to strictly control public spending and public sector borrowing.

This resulted in clapped out and crumbling facilities – and mounting private sector pressure for profitable contracts to be opened up. It had also resulted in the nationalised industries being starved of funds and in-house pressure for their privatisation to escape the financial straightjacket.

The Thatcher government had eagerly privatised the nationalised industries – but had baulked at privatisation of the NHS, which faced an unprecedented squeeze on its budgets (only surpassed by the squeeze imposed from 2010).

PFI appears to offer a way to keep public control of the services supplied in public facilities while turning to the private sector to provide funding, to take on the construction risk and to manage the facilities over the life of the asset according to a contract agreed in advance … and to generate very lucrative returns for shareholders as a result.

It offered many of the benefits of privatisation to the construction and banking sector, while leaving responsibility for paying for the new buildings in the public sector, and thus guaranteeing the flow of funds to cover the rising bills. It was to provide a rich vein of profits.

The move to embrace PFI as a policy meant breaking from rules specifically designed to guard against public sector bodies embarking upon schemes which might undermine tight controls on public spending.

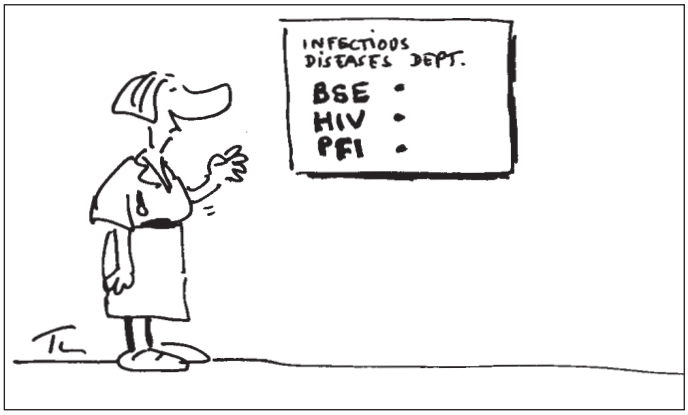
Assets now long-term liabilities

However while it breached these rules, PFI was clearly in keeping with the post 1980 ideological frameworks of neoliberalism (with its obsession with maximum private sector role, free markets and minimum public/state involvement) and of "new public management" which centres on a maximum level of contracting out services and tasks to the private sector, and "steering, not rowing".

Lamont's successor as Chancellor, Kenneth Clarke, was an even more enthusiastic promoter of PFI, which he famously summed up in a 1993 speech to the CBI as: "Privatising the process of capital investment in our key public services."

The policy was eventually branded as the Private Finance Initiative – PFI – although the acronym was soon to be parodied as "Profits For Industry", "Profiting From Illness," or simply "Pure Financial Idiocy".

The concept was relatively simple. PFI required projects above a certain minimum scale (in the NHS this was initially above £5m) to be opened up for bids from the private sector to finance the scheme, with repayments over a prolonged period of 25-30 years or more.



Rather than owning new hospital buildings, the NHS Hospital Trusts, (many still newly established, or just emerging after the controversial "internal market" reforms in 1990) would become leaseholders, required to make annual, index-linked payments for the use of the building and support services provided by contractors for the lifetime of the contract, which could be anything up to 60 years.

Hospitals built on this basis would no longer be public assets, but long-term public liabilities incurring increasing payments for a generation or more ahead. These capital schemes were not investments, but new forms of public sector debt. NHS trust management would be left in control only of clinical care, while other support services including maintenance of the hospital buildings was to be done by profit-seeking private companies.

The 1990 Act had also established a new system of "capital charges" under which NHS Trusts had to pay a 6% charge on their net assets each year to the NHS Executive. The rationale for this was to in effect charge trusts a "rent" to mirror commercial pressures to make a return on assets employed in a business.

Its effect was to normalise the idea of NHS hospitals paying out from their core income to cover the costs of buildings and equipment: but there was a difference. While the NHS capital charges effectively recirculated within the NHS itself, the payments for PFI hospitals would flow out of the public sector … and in to the coffers of private companies, of which a sizeable share would be scooped out as profit or dividends.

In November 1994 Clarke went further, and proposed a massive £5 billion reduction in public spending, telling the CBI conference that in future the Treasury would only provide capital for projects as a last resort – "after private finance has been explored."

However progress on PFI contracts was slow. By July 1996 angry and frustrated CBI leaders warned Clarke that PFI could fail without more decisive action. They were angry at the bureaucratic delays and costs which were holding up key infrastructure projects.

Tory legislation in 1996 was expected to free the logjam by giving a commitment that the government would effectively act

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as guarantor for any debts to PFI consortiums if one or more Trusts went bankrupt. Some trusts could be "winners" in the new, competitive, NHS 'internal market' – but others had to be losers.

Tory ministers believed their short Bill that was passed was sufficient – but they were soon proved wrong when one of the banks involved in the Dartford Hospital project raised doubts.

So despite all the negotiations and considerable expenditure on legal and accountancy advice, no hospital PFI schemes were signed under the government which invented PFI.

Some prominent Tories even warned that PFI might in fact prove not to be such a great idea after all. Even Norman Lamont, who first launched the PFI programme, later had doubts and in his memoirs in 1999 predicted the problems that were soon to befall hospital PFI projects:

"The government itself can always borrow money more cheaply than any private sector borrower, so the efficiency test of a private finance project has to be real...

"I suspect that in the long run some of these projects will go wrong and appear again on the Government's balance sheet, adding to public spending. We shall see."

Labour's response – from denunciation to promotion: Tony Blair won the 1997 election with a massive majority, raising high popular expectations of radical change. However, to the delight of a few and the dismay of many, Blair's New Labour government appointed ministers even more attentive and eager than the Tories had been to satisfy the demands of the banks.

The new government's only legislation on the NHS in 1997 was another short Bill to facilitate PFI. The National Health Service (Private Finance) Act was pushed through with just one amendment allowed, and with one aim in mind – to "remove any element of doubt" among the bankers that, despite all the tough-sounding rhetoric insisting that PFI contracts transferred risk to the private sector – there was no real risk at all, and their money was safe.

The health minister who pushed the new Bill through parlia-

ment, Alan Milburn, made clear the Bill was intended first and foremost to give the bankers just what they wanted: "[It's] about removing doubt, providing certainty, and above all getting new hospitals built".

A Labour peer, Baroness Jay revealed who was effectively dictating the legislation: "the banks concerned have seen and agreed the wording of the Bill and have made clear that it satisfies all their concerns."

New Labour had completely changed its position on PFI, from a sceptical rejection in 1993, to embrace the policy enthusiastically and nurture it as their own in 1997. New Labour ministers now insisted that for the "overwhelming majority of new hospitals" limited availability of public capital meant it was now "PFI or bust".

Two years earlier Margaret Beckett, as shadow health secretary, had toughened up Labour's critical response, telling the Health Service Journal: "As far as I am concerned PFI is totally unacceptable. It is the thin end of the wedge of privatisation."

But in the summer of 1996 Shadow Treasury minister Mike O'Brien announced a reversal of New Labour's policy: "This idea must not be allowed to fail. Labour has a clear programme to rescue PFI"

The "rescue of PFI" was duly included in New Labour's 1997 manifesto, sitting strangely alongside promises to scrap the NHS internal market. The pledge to scrap the market rather predictably proved to be an empty one: but the promises to implement PFI were sincere enough. By the spring of 1998, PFI was declared to be: "A key part of the [New Labour] Government's 10 year modernisation programme for the health service."


HEALTH EMERGENCY

INSIDE this BIGGER 50th issue:

Bulletin of Hands Off Our NHS * No.50 * Summer 1999

PFI: THE COSTLY NIGHTMARE CONTINUES

KEEP ACCIDENT & EMERGENCY LOCAL

CASUALTY CLOSED MORTUARY FULL!

Not so super

Simply a 'scam'

While Kenneth Clarke had openly boasted that PFI would generate new profits for the private sector, New Labour, insisted using private investment to modernise public services was a "partnership," an example of the 'Third Way' , finding common ground between neoliberalism and social democracy.

Milburn went further still and told MPs PFI could deliver actual savings as well as value for money, stating: "… any scheme that is given the go-ahead has to prove it is cheaper, better, better value for money and better for patients than the public sector option, and I am convinced from all of the work that I have seen from officials that all of these schemes we have given the go-ahead to and all the schemes that we will give the go-ahead to in the future will prove, if they are built through the PFI, better value for money".

However opinion elsewhere had hardened up against PFI. According to Guardian financial columnist Larry Elliott in the same year, PFI was simply "a scam": "Of all the scams pulled by the Conservatives in 18 years of power -and there were plenty -the Private Finance Initiative was perhaps the most blatant. ... If ever a piece of ideological baggage cried out to be dumped on day one of a Labour government it was PFI."

Despite its popularity with New Labour ministers (most notably with the Treasury team) PFI soon began to incur the increasingly vociferous opposition of the BMA, the Royal College of Nursing, UNISON and almost all trade unions, local campaigners in affected towns and cities, and a growing body of academics.

PFI came to be associated with funnelling profits to the private sector and contracting out/privatisation of support services.

Nevertheless as soon as the 1997 Act went through Parliament the go-ahead was suddenly given to 15 hospital projects in 1997, prior to devolution, so the first list of schemes agreed included one in Wales and three in Scotland.

One of the most remarkable features of these early projects, looking back, is the comparatively low capital costs of new PFI hospitals. 17 of the first 22 PFI hospitals were costed at below £100m. Even including the more expensive schemes the first wave schemes averaged less than £100m each.

However most first wave PFI hospitals – which in most cases brought sharp reductions (ranging from 20%-40%) in bed num-

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bers – struggled both financially and clinically as a result of flawed schemes. Several of these same schemes are still in severe difficulties now, 21 years after the first of the PFI hospitals opened.

The bed reductions flowed from a combination of strenuous efforts to hold down costs by restricting the scale of the new buildings on the one hand, and on the other hand the involvement of management consultants committed to the introduction of "innovative methods," who made hugely over-optimistic assumptions on the increase in throughput of patients per bed that could be achieved through the move to a new building – and sharp reduction of average length of stay.

In Worcestershire, for example, the PFI scheme, shaped by management consultants SECTA and the propositions put forward by the King's Fund, sought to reduce bed numbers by 35%, and cut beds per 1,000 patients by 40%. This meant hoping for a truly massive increase in throughput per bed by reducing average length of stay – without any actual evidence that this could be achieved.

These issues appeared very abstract and theoretical when the proposals were first revealed, since no new hospital projects had begun since 1993. To make matters worse it was difficult to get any detailed or serious public discussion or political critique of specific issues and schemes: the media remained largely oblivious to the whole question of PFI, and MPs and pro-PFI enthusiasts were keen to brush aside and ridicule any critics of the scheme, dismissing them as negative opponents of building a new hospital.

Such was the pent-up level of expectation of quick results that when in 1997 another 23 schemes were postponed to future rounds, it was described by Financial Times health correspondent Nick Timmins as the biggest-ever "hospital cancellation programme".

However experience over the following 20 years has vindicated many of the critics who warned that buildings would be too small, often in the wrong location, and bring excess costs – in some cases so substantial that other much-needed local service developments became increasingly unaffordable.

In one South East London trust, Queen Elizabeth Hospital, Woolwich, which opened in 2002, the scale of the financial problem reached the level of 'technical bankruptcy' just 3 years later, with the trust paying out 14.5% of its income on the "unitary charge" for use of the building and support services, according to a 2005 Audit Commission report. This was to cause even bigger repercussions from 2011 onwards, as we will see later in this series.

PFI also failed to deliver on another measure of value for money: many staff working in the new hospitals, especially the first wave PFI hospitals, were profoundly unimpressed by the quality and design of the buildings, criticising predictable practical problems, compounded by the limited or non-existent prior engagement with staff in drawing up the plans, and the failure to learn lessons from the first hospitals before completing plans for others with similar problems.

John Lister

** This article is based upon part of the introductory chapter to the book Unhealthy Profits, written by John Lister for UNISON Mid Yorkshire Health Branch of UNISON and published in 2018.*

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