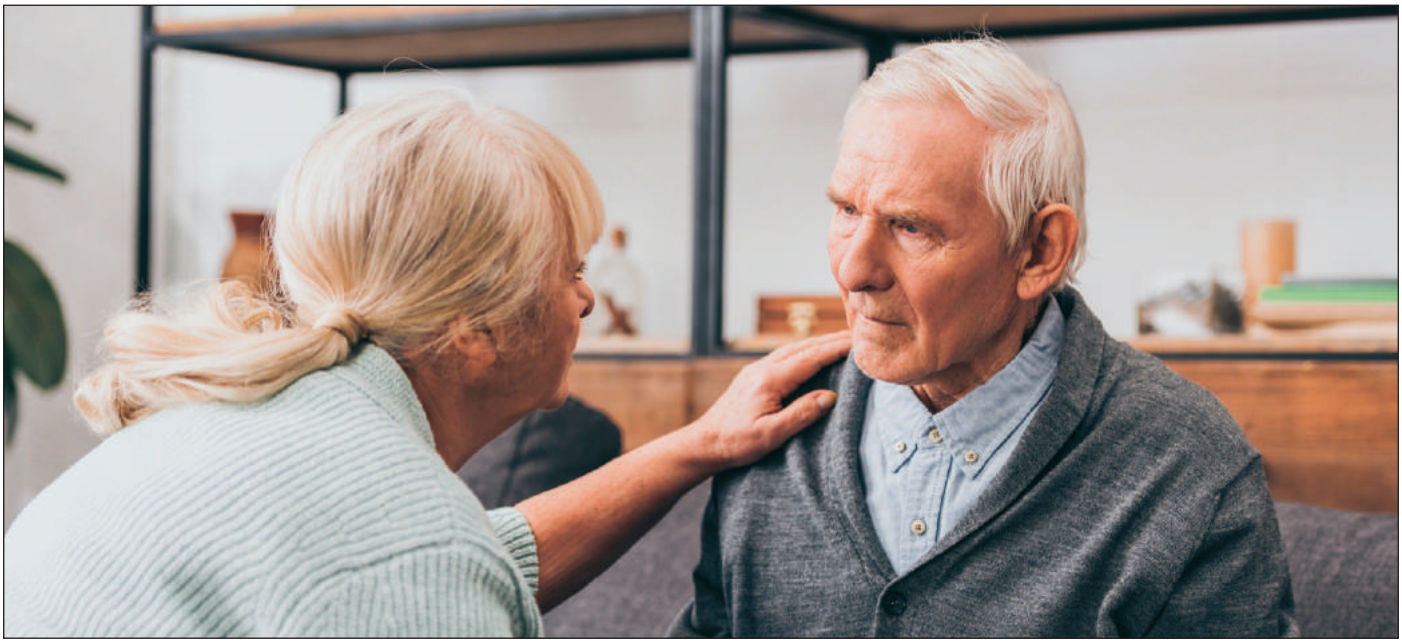
The lowdown

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

Dementia Action Week: End the injustice of dementia patients paying for their care



Let down again, charities and campaigners representing 850,000 dementia patients were united in their criticism of the government this week for failing to produce a solution to the social care crisis, and bring an end to a great injustice at the heart of the health system.

Over 40% of dementia patients end up paying for the aspects of their own care, unlike patients with cancer, heart problems or diabetes, or other chronic conditions treated on the NHS.

It is over twenty years since the Royal Commission on Long term care, set up by the Blair government, highlighted this injustice and suggested that aspects of these care costs should be met by the state. These proposals were rejected, and shamefully this issue still sits stranded in the current government's intray, despite Johnson's promise on the steps of Downing Street to "fix it". Meanwhile the colos-

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sal social and economic costs of inaction mount.

Caring for patients with dementia and helping them to manage their symptoms involves daily support, and for many patients this help is defined as social care which, unlike NHS care, is means-tested.

Families are often shocked to find how little financial support exists for care costs. If you have assets of over £23,000 (including your house) then you have to pick up the costs of your care yourself.

According to the Alzheimer's Society the typical cost for the care of a patient is around £100,000 and sometimes up to £500,000 which explains why upto 30,000 people a year end up selling their homes to pay it.

"Vague promises are no longer enough... It is time for the government to take the next vital steps and honour their promises with a concrete plan" – Alzheimer's Society

While successive governments in Westminster have dodged the difficult decisions on social care, nearly two decades ago Scottish political leaders took the bold step to provide free personal care, a step rejected south of the border. Help with eating, bathing and dressing - daily tasks that dementia patients need help with, are all funded by the Scottish government.

People in Scottish care homes, aged over 65, who require personal care receive £174 a week to cover their costs. An extra payment of £79 is made for those who need nursing care. These payments are made by local authorities with Scottish Government funding.

NHS support is only available for patients who qualify for a funding pot known as Continuing Care, but only the sickest patients can access it. Many dementia patients don't meet the criteria.

NHS care is available from GPs and through specialist services such as memory clinics, which are free to access, but day to day support often has to be paid for, or is shouldered by an army of unpaid carers.

Back in 2014 the Alzheimer's Society estimated that "over 670,000 people in the UK were acting as primary, unpaid carers for people with dementia" and the National Institute of Health Research says this is worth an estimated £14 billion each year.

Some commentators see this as a sensible way to offset the burden from the taxpayer, but research has identified that it comes at a higher cost by taking people out of the workforce, reducing tax receipts and incurring extra health costs.

The cost to businesses alone from employees taking time off to care for people living with dementia, was estimated to be £3.2 billion in 2019 according to the Alzheimer's Society - 21 per cent of carers give up work or reduce their hours.

Problems with supply

The care sector was financially strained before the pandemic, 400 care homes have already closed over the past 5 years, but the extra costs of covid is threatening the future of many care businesses. Most are now run on a commercial basis - 84% of care homes are run by the for-profit sector, 13% by the voluntary organisation and only 3% are run by local councils. The UK ranks lower than Belgium, the Netherlands, France and Germany, with only 43 beds per 1000 people aged over 65.

Lack of social care has led to 2.5 million lost bed days in the NHS in the five years up to the end of 2019 according to Age UK.

Over the same period delayed discharges' have cost the NHS a total of £587 million. One of the major reasons for these delayed days is a lack of social care support in the community, either at home or in a care home. The number of emergency admissions to hospitals of people with dementia has risen by 70% in five years at a cost of £400 million, potentially avoidable if more care were in place.

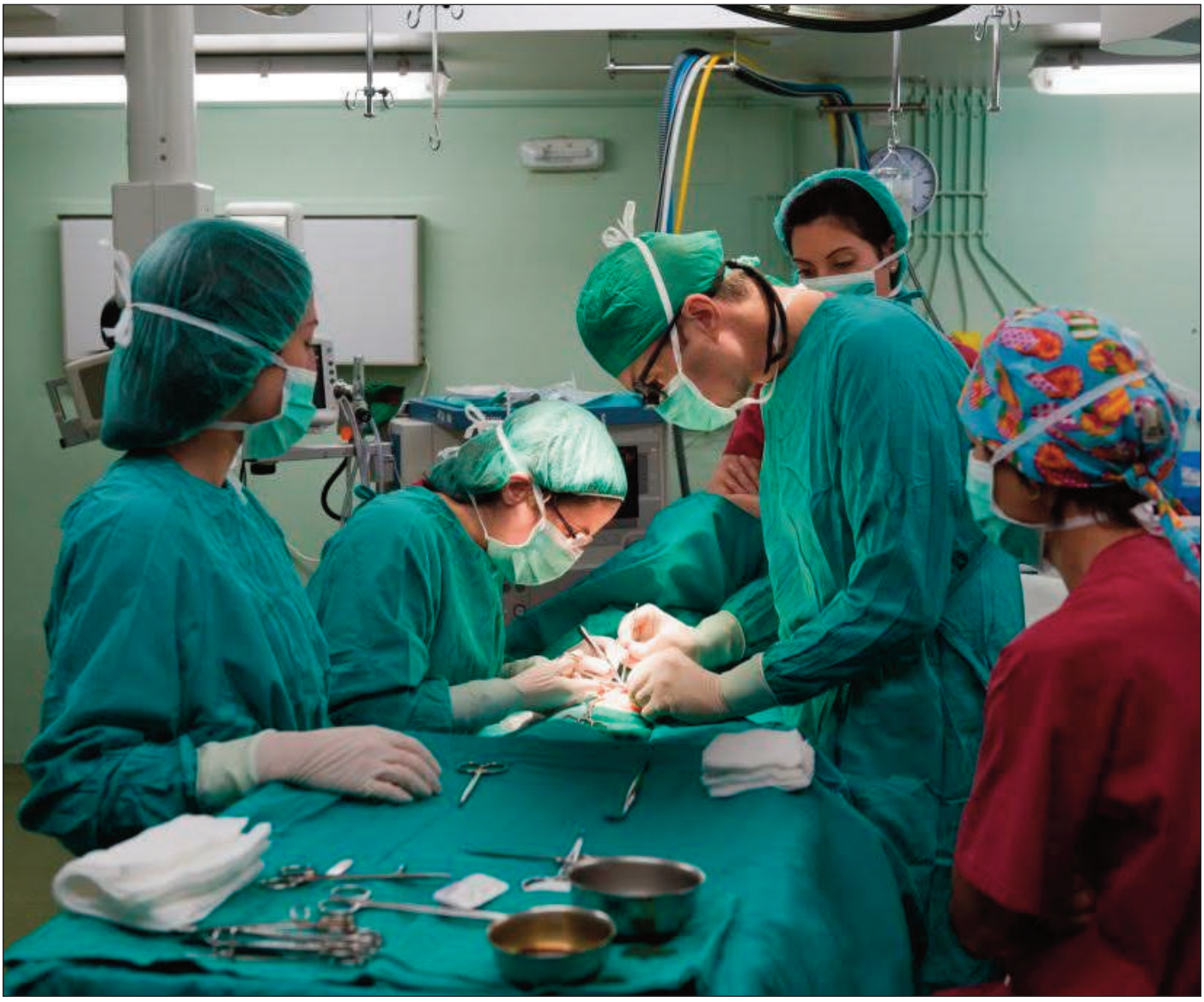
The government needs to lift overall spending on social care by 12.2bn to 2022/23 – based on estimates by the Health Foundation and this funding should be aimed at the 1.5 million people who Age UK say aren't receiving care at the moment.

Unison is pushing for a scaling up of public sector provision, through a national care services. Unsurprisingly low pay and poor working conditions are prevalent. A quarter of care staff are employed on zero-hours contracts. There is a big turnover, a third of care staff leave their roles each year and there is a major shortfall of 120,000 staff, which could double by 2030.

Paul Evans

For more information on Dementia Action Week, visit www.alzheimers.org.uk/get-involved/dementia-action-week

Independent sector looks to boost NHS work, despite transparency failures



Figures released last week showing almost 5 million people are waiting for hospital treatment in England, with more than 430,000 waiting more than a year, are – even allowing for the impact of the pandemic – a national disgrace. But they also signal a useful income stream for the private health sector over the next few years while the backlog is cleared.

The pandemic is certainly turning into a 'win win' situation for private operators. Employing staff trained at public expense within the NHS, some of these companies are in the fortunate position of being paid to help the health service reduce its waiting lists, while also potentially earning more per head from a growing number of patients desperate to jump the NHS queue by 'going private'.

Working on those waiting lists has considerable PR benefits for private contractors too – just look at the websites of Circle, Spire and Transform and you'll see how they all proudly talk up their input during the pandemic – and the sector is understandably keen to forge new kinds of public/private healthcare

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partnerships, given the vast sums up for grabs from the taxpayer.

Last month, commenting on the latest waiting list figures, Independent Healthcare Providers Network chief executive David Hare told market intelligence agency Laing Buisson that, "The NHS and the independent sector will build on this extraordinary [backlog] partnership to give NHS patients access to the best possible NHS care, free at the point of use."

Commercial operators already have a very strong presence within the health service: they're responsible for a third of all hip operations and a quarter of knee replacements, as well as more than 20 per cent of gastroenterology, trauma and orthopedic NHS treatments. That's over 500,000 non-urgent NHS operations and procedures in total.

And they're hoping for more. As the Guardian discovered last year, the head of one of the key, long-standing beneficiaries of the government's taxpayer-funded healthcare largesse – Serco's Rupert Soames – has privately suggested that the pandemic could go "a long way to cementing the position of private sector companies in the public sector supply chain".

Labour Party research, released earlier this month, shows that during the past decade non-NHS healthcare providers banked £96bn-worth of health service funding. The annual figure rose from £8.4bn in 2010 to £14.4bn in 2020, the latter representing almost 12 per cent of the NHS' total operating budget.

Propped up by the NHS

However, the picture isn't always as rosy as the private sector might have you believe. The Lowdown noted last month that some independents were actually being propped up by the NHS – almost half of Spire's total revenue in 2020 came from the NHS, for example, as did the bulk of Ramsay Health's UK income – while a recent report from Laing Buisson found that nearly half the profit in the UK independent sector has disappeared since 2014.

And while it's true that NHS surgeons were pleading with chancellor Rishi Sunak in April last year for extra funding to pay for treatment in private hospitals (and are still pleading), the billions spent and often wasted elsewhere on private contracts to support the health service during the pandemic – to run the underperforming NHS Test & Trace operation, for example – have been well documented by the National Audit Office.

Concerns remain about the private sector capacity block-purchased by NHS England last year. Documents leaked to HSJ in December show that only a third of this capacity was used by the health service over last summer, despite reportedly costing around £400m a month simply for access to facilities, rather than how much work was actually carried out.

HSJ quoted one senior health service manager who questioned the value of the public/private deal, and said, "The national contract for private sector capacity was for the company shareholders, not for NHS patients."

However useful the block-purchase deal was to the NHS, it ended last August, triggering a resumption of routine elective care in private hospitals employing NHS staff while the health service was still dealing with the pandemic.

This led several senior NHS clinicians in January to lobby medical directors at London's acute hospital trusts, urging them "not to support" staff working in the private sector, according to HSJ. One clinician allegedly accused doctors working in the independent sector as "taking the piss and walking off with the money".

Tax dodges and hidden profits?

Sadly, the cynicism of that clinician appears justified when considering the sometimes dodgy ethics and lack of transparency revealed almost daily in media coverage of the NHS' relationship with the private sector.

Only last week, for example, the Guardian uncovered potential tax scams by recruitment agencies supplying staff to NHS Test & Trace call centres and testing sites, and also to the Lighthouse lab in Milton Keynes. The alleged tax-dodging involves the use of 'mini umbrella companies', often fronted by directors in the Philippines – an arrangement that HM Revenue & Customs suggests can often be fraudulent and which deprives the taxpayer of millions each year.

And with £10bn now on offer under an NHS England framework agreement based on a list of 90 approved private companies, taxpayers hoping for some transparency must surely be concerned by news the government is reluctant to reveal details of £2bn-worth of covid-19 contracts awarded since March 2020 – some to suppliers with financial links to the Conservative Party.

Profit levels are a particular concern, as the government seems to be claiming services were provided at 'cost price', but annual accounts for individual suppliers suggest work was often supplied on a 'cost plus' basis.

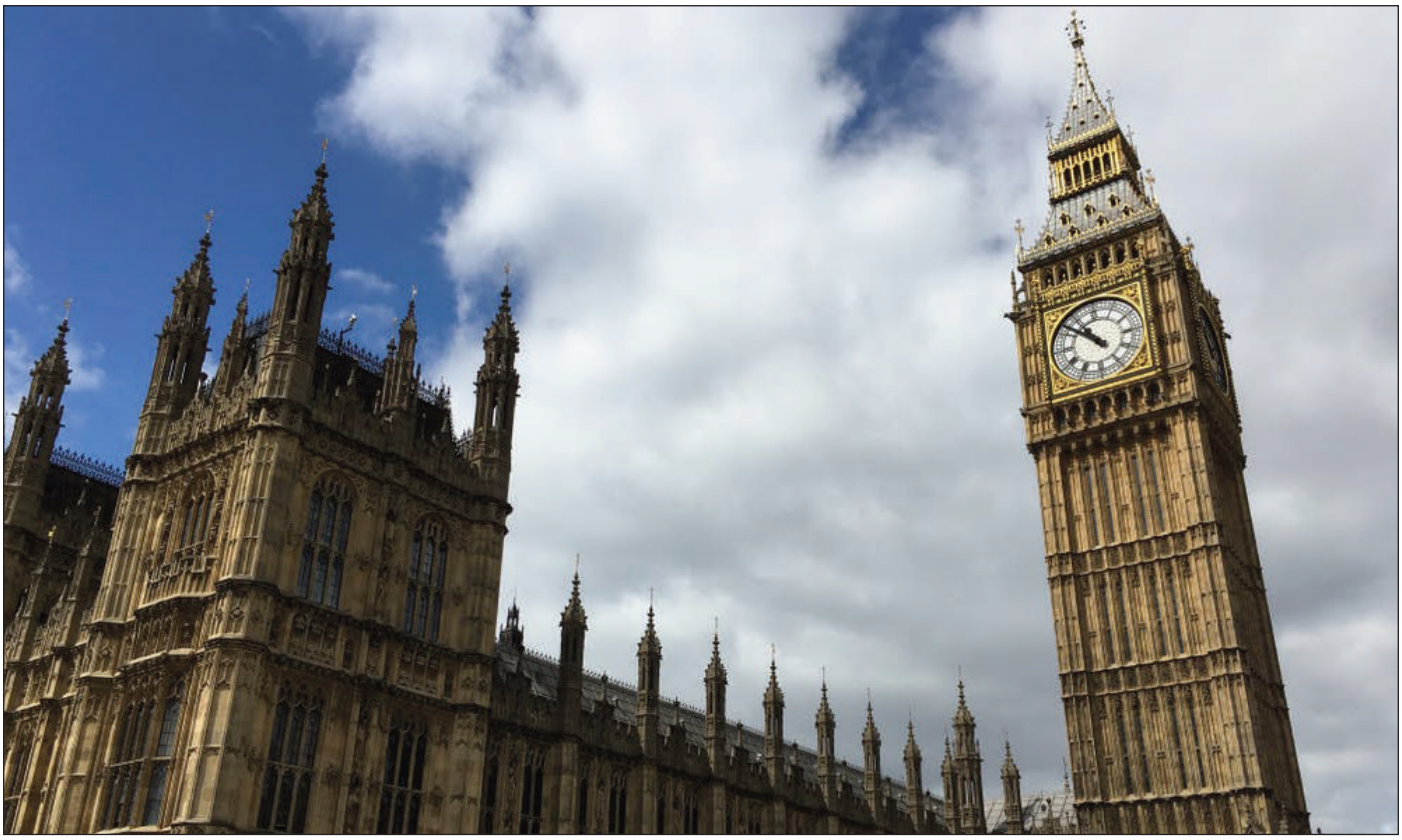
Limited oversight

With the government presenting an 'always open' door to commercial interests lobbying for NHS work, monitoring the costs and the performance of those private contractors has never been more essential, but with the use of judicial reviews (currently the most effective way of holding the government to account) now under threat – as flagged up in last week's Queen's Speech – it's currently uncertain how this monitoring can continue.

A worrying scenario, and a strong argument for reducing, not expanding, the NHS' links with the private sector.

Martin Shelley

What will be in the Health and Care Bill?



The 2021 Queen's Speech lacks any details of the proposed 'Health and Care Bill' we might have expected to be based on the February White Paper "Integration and Innovation".

Notes published in advance of the speech by the House of Commons Library anticipated legislation along the lines of the White Paper, including proposals previously set out by NHS England:

– "To establish Integrated Care Systems as statutory bodies and other measures to support integration of health and care"

– "To formally merge NHS England and NHS Improvement"

– "Changes to procurement and competition rules relating to health services"

Legislation simply to 'empower'?

It also anticipated additional proposals that were included for the first time in the White Paper, to give additional powers for the Secretary of State "including powers over NHS England, Arm's Length Bodies and health service reconfigurations, and powers to create new Trusts."

Whether or not all or any of these will be included in the new Bill is now anyone's guess, since the Queen's Speech itself bears so little similarity to the expected content. On the NHS the relevant section said simply:

"My Ministers will bring forward legislation to empower the NHS to innovate and embrace technology. Patients will receive more tailored and preventative care, closer to home [Health and Care Bill]. Measures will be brought forward to support the health and wellbeing of the nation, including to tackle obesity and improve mental health."

The accompanying Briefing Notes don't add much, summing up the main elements of the Bill as:

- "Driving integration of health and care through the delivery of an Integrated Care System in every part of the country.
- "Ensuring NHS England, in a new combined form, is accountable to Government, Parliament and taxpayers while maintaining the NHS's clinical and day-to-day operational independence.
- "Banning junk food adverts pre-9pm watershed on TV and a total ban online.
- "Putting the Healthcare Safety Investigation Branch on a statutory footing to deliver a fully independent national body to investigate healthcare incidents, with the right powers to investigate

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the most serious patient safety risks to support system learning."

Missing completely from this bland summary is the much-vaunted proposal from NHS England, echoed in the White Paper, to scrap the controversial Section 75 of the 2012 Health and Social Care Act, and the associated regulations which effectively required Clinical Commissioning Groups to carve up an ever-increasing range of services into contracts and put them out to tender, inviting private as well as NHS providers.

When these proposals were included in a leaked version of the White paper, the story was spun by both the BBC and the Times to suggest the plans were a step to "scrap forced privatisation and competition within the NHS".

Inappropriate and misleading

This reading of the proposals was especially inappropriate after a year of pandemic measures had massively increased the level and proportion of health spending on private providers – with billions spent on privatised test and trace, huge sums spent on private management consultants, and billions more on the use of private hospitals to treat NHS patients, with plans to continue and increase this over the next four years at a cost of up to £10 billion.

Focusing on the tiny percentage of contracts subjected to competitive tender is also a misleading way of assessing the level of outsourcing of NHS services to private providers, since the bulk of this is now done through 'framework contracts' established by NHS England that list a range of pre-approved private and other providers, from which CCGs and trusts can choose without any competitive process.

And more recently NHS England itself is now promoting the idea of handing new contracts to run imaging networks in each Integrated Care System to commercial companies as one of two possible ways forward.

But if the Bill, now expected to be published next month and debated into the autumn, turns out to be as vacuous as the Speech and Briefing Notes suggest, then much of the debate over this aspect of the White Paper will turn out to have been misdirected.

However in preparation for the likelihood of the Bill being based more substantially on the White Paper, and given the Johnson government's 80-strong majority, campaigners wanting to fight any of its damaging proposals will need to focus on issues and demands for amendments that might win broad enough popular support to split some Tory MPs and secure amendments.

Shadow Health Secretary Jonathan Ashworth MP told The Lowdown:

"We need to see what is included in the Bill. We obviously want to see genuine integrated, coordinated care for the patient, but that must be delivered by well-funded, publicly-provided, properly qualified primary care, working in partnership with community and secondary care.

"What is being proposed in the White Paper is a new confusing bureaucracy, with opaque decision making and little accountability to the public, allowing contracts to be handed out to private interests with no challenge. We've already seen what that means with a string of GP practices disgracefully handed to a US health insurance company. Labour will not be supporting anything that allows this or any other extension of private provision of the NHS.

"Moreover with waiting lists at record levels risking a middle class flight to the private sector the response must surely be a properly funded and staffed NHS with decent pay and conditions, not imposing financial straightjackets that can only lead to more rationing locally.

"Labour will be fighting in Parliament and the across the country for a publicly provided, fully funded comprehensive NHS."

Suggested amendments

Demands for amendments to the White Paper which might draw wide support include:

– barring the new statutory Integrated Care Systems from including any private sector representatives on their Boards. Instead, independently appointed or elected representatives of public, patients and trade unions should have a place on every Board.

– requiring all ICS Boards to meet in public, offer online access, publish their minutes and Board papers and be subject to the Freedom of Information Act.

– a clear and statutory requirement for accountability and scrutiny by local government at the most local "place" level within each ICS.

– maintaining the right of local authorities to refer controversial changes to the Secretary of State, and the Independent Reconfiguration Panel, which must be made more representative, not abolished.

– establishing NHS as the default provider when existing contracts expire. ICSs must be required to consult publicly before awarding a contract for any existing services to a private provider.

– requiring any ICS to publish fully without any claim to commercial confidentiality all proposals for contracts, the contracts themselves and the outcomes of regular contract monitoring.

– no private provider should be approved for any NHS contract who does not pay staff at least the equivalent of NHS terms and conditions

John Lister

Is online access to GPs increasing their workload?

GPs are calling for a full assessment of the impact of digital technology on their workload as data shows that demands on GPs have escalated rapidly fueled by technology, such as e-consult, that allows simple access to GPs via an online form.

A motion at the UK LMCs (Local Medical Committees) conference last week asked the GP committee of the BMA to 'conduct a full impact assessment of the effect of the roll-out of uncapped instantly available e-consultations on the availability of more proven consultation models'.

The Royal College of GPs (RCGP) new report - General practice COVID-19 recovery: the future role of remote consultations & patient 'triage' - calls for "research into models of triage and remote consultations to evaluate the effectiveness and efficiency of existing methods" plus "review and improve digital patient triage platforms and processes, and produce guidance for patients and staff to support effective implementation".

The LMC motion and RCGP report follows growing disquiet over the massive increase in workload for GPs following the mandatory introduction of technology that allows remote consultations at the start of the Covid-19 pandemic back in March 2020. What began as the answer to the problems of seeing patients during the pandemic has now resulted in a massive increase in workload for many GPs as the public takes advantage of the ease of access via on-line forms

Doubling of demand

It came to a head for a surgery in Derbyshire at the end of April; the Ivy Grove Surgery had seen demand double in previous months despite encouraging patients to use eConsult 'in a responsible manner'. E-consult is the technology that has been most commonly put in place by surgeries.

In a 16 page open letter to patients the surgery outlined how it had been overwhelmed with online queries and its 16 phone lines had remained as busy as ever. The surgery likened adopting online consulting to "opening up a brand new lane on a full motorway that was already littered with roadworks and having an instant traffic jam as a result".

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Issues included multiple requests from patients in a day and people who seemed unable to tolerate any symptoms of ill-health at all and demanded instant treatment for conditions such as sore-throats, earache or diarrhoea as soon as symptoms appeared rather than taking self-care advice from the many sources on the surgery's and the NHS' websites.

Then if patients did see a GP they often came with a list of complaints all of which were expected to be dealt with in a 10 minute slot. The surgery also said that they had hoped that the use of e-consult would have freed up the phone lines for elderly and vulnerable people that they knew might struggle with IT, however the surgery found a significant group that despite the simplicity of e-consult had decided to not use it but ring instead.

Taking a step back

As a result of the increase in workload, the surgery has decided that it will "now be returning to a more traditional service, similar to that which existed before covid, in which appointments will be allocated to those in clinical need". The surgery will be reducing its emphasis on e-consult.

The Ivy Grove surgery is not alone in its difficulties with e-consult (or similar services). Other surgeries have turned off their digital services over the weekend in an effort to stem the tide.

The data backs up the reports from GPs of escalating workload; for March NHS Digital reported that GPs saw more patients than in any other month since records began.

The monthly NHS Digital dataset showed GPs delivered 14.7 million appointments in March 2021, including Covid-19 vaccinations, compared to 12.8 million in March 2020 year. However, it is also significantly higher than for March 2019, when GPs saw 13.6 million patients.

A recently published survey of 1,400 GPs by Pulse found that GPs are working 11-hour days, dealing with an average of 37 patients in that time, although GPs believe that 28 patients is the safe daily limit in the pandemic.

Everything is taking longer, according to the GPs surveyed - face-to-face consultations because of the need for PPE and cleaning rooms in between consults and telephone consultations because of the extra time needed to read the e-consult forms and waiting for someone to answer the phone. GPs also worry about missing vital clues from patients' body language during telephone consultations.

GPs also report that there has also been an increase in patients "consulting by email"; rather than using official e-consultation forms patients are using the contact email for the surgery and requesting messages are passed on, meaning there's a risk the messages will be missed.

The current GP crisis predates COVID-19 by many years, but has been highlighted and worsened by the pandemic. Pledges for 5,000-6,000 more GPs were made back in 2015, with a deadline of 2020, and again in 2019 with a deadline of 2024. These extra GPs have not materialised.

But there is a twofold problem here - both a lack of GPs, and the behaviour of a section of the population when access to a GP is made very easy.

Digital technology has torn down any barrier to accessing GPs - no need to wait on the phone or deal with a receptionist - now e-consult forms can be filled in and sent 24/7.

An editorial by Jaimie Kaffash, editor of Pulse, noted that "A measure of awkwardness – or, as one LMC representative puts it, a 'bottleneck' – to getting through to a GP is an absolutely essential part of the process." He added that the GPC "should not focus its efforts on getting the tools to meet demand, in the form of extra staff. Instead, it should be encouraging the bottleneck."

However, the replies to Jaime Kaffash's editorial tweet show that opinion is divided on the best approach to deal with the demand. Clare Gerada, member of RCGP and BMA, noted," The problem is not enough GPs. Not digital" and in a separate tweet asked why the LMC are "not using this increased activity to lobby for more staff. They are shooting themselves in foot saying it's unnecessary demand."

E-consult here to stay

Another GP noted that the bottleneck in the past was who had "the most time (or phone credit) to spend to be put on hold, or who could wake up early enough to make a call to book an appointment or wait to see GP in a walk-in etc." and GPs worried then about who they had missed.

Whatever the opinions of the GPs, e-consult is here to stay. Matt Hancock, the Minister for Health and Social Care is an enthusiastic supporter of the use of digital technology in the NHS. In a speech back in July 2020 to the Royal College of Physicians, he said that all GP appointments should be done remotely by default unless a patient needs to be seen in person. In March 2021, an NHS England guidance document noted that "systems are asked to continue to support practices to increase significantly the use of online consultations, as part of embedding total triage".

The RCGP disagrees on remote consultation as default and notes in its report General practice COVID-19 recovery: the future role of remote consultations & patient 'triage' that "face to face consulting is an essential element of general practice and remote consulting should be an option but not the 'automatic default' for GP care." .

Sylvia Davidson

The history of NHS privatisation pt 5: the arrival of Blair (1997-2003)

The victory of Tony Blair's New Labour government in 1997 came at a time of huge and growing waiting lists for care, with waits of more than a year commonplace and delays of over two years far from rare.

Yet the first three years of the new government remained locked in to the limited spending plans outlined by Tory Chancellor Kenneth Clarke, with only limited efforts to contain the waiting lists.

Only in 2000 did the policy change to one of large scale year-on-year increases in NHS spending designed to increase towards the average spending of comparable European countries. As a result after 50 years of limited growth, health spending as a proportion of Gross Domestic Product rose from just 6.3% in 2000 to 8.8% in 2009.

The increase in spending allowed for recruitment of additional staff, a substantial uplift in NHS pay linked to the Agenda for Change agreement finalised in 2004, the reopening of some beds and avoiding cash-driven closures – and the beginning of a serious drive to reduce delays in A&E (with a new target to treat or discharge within 4 hours set in 2004 and achieved in 96% of cases by 2005).

Similar targets were set for elective surgery waiting times, culminating in 2005 (when the waiting list numbered 856,000) with an election commitment to reduce the maximum wait to just 18 weeks from referral to treatment.

However the investment and the commitment came with extensive strings attached. The broad strategy was set out in the NHS Plan launched in 2000 by Health Secretary Alan Milburn. It combined measures to entrench and institutionalise the market system that Tony Blair had correctly condemned as 'costly and wasteful' and committed to scrap in the 1997, and to extend the scope of outsourcing well beyond the previous range of non-clinical support services, to include diagnostic services (new diagnostic and treatment centres) and elective hospital treatment as well as provision of so-called "intermediate beds".

The New Labour approach was later summed up by Blair's Pensions Secretary John Hutton in a 2007 speech to the CBI in which he argued that the "core" of the reform programme including "an open minded approach to who provides" – was being "built into the DNA of our public service infrastructure."

But increasingly it became obvious that ministers were far from open minded; indeed they became ideologically obsessed with

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bringing in private companies and private hospitals as so-called "partners" – at the expense of sidelining and destabilising existing NHS providers.

Concordat with private sector

The starting point on this new trajectory to privatising clinical care came in June 2000 when Alan Milburn, having taken over as Health Secretary from Frank Dobson, proudly signed a "concordat" with private hospitals, under which they would treat uncomplicated NHS waiting list patients during winter and other peak periods when local NHS trusts lacked the capacity to deal with combined emergency and elective demand.

This was initially welcomed by the BMA and of course by the private hospitals, but perhaps surprisingly criticised by the Tories as "hypocrisy": Tory statements highlighted a doubling of NHS spending on private health care since 1997. It was opposed by the Labour left and campaigners, who warned of the slippery slope towards greater privatisation of elective care.

The problem then, as now, of course was that the funding to pay the private hospitals and the staff to deliver the treatment were taken from the trusts under the greatest pressure, and meant that there was no way for them to escape by investing in expanded NHS capacity.

Indeed it was later revealed that the scheme was a double blow to trusts' finances, with treatment costs for NHS patients admitted to private hospitals a staggering 40% higher than the NHS. Hip operations costing an average £4,700 in the NHS had been charged at over £6,800 by private hospitals.

The concordat was a massive boost for a flagging private hospital sector, where bed occupancy had been commonly averaging 50-60%. By January 2001 Manchester's BUPA Hospital boss Stephen Bird was delightedly reporting 100% occupancy, with the empty beds filled with NHS patients.

At the end of 2001 a further deal was announced, in which the NHS would commission 5,000 routine operations such as hip and knee replacements from BUPA's 36-bed Redwood Hospital in Redhill, East Surrey: the deal involved the transfer of 27 NHS nursing staff from East Surrey Hospital, while all of the consultants listed as working at Redwood hospital were NHS employees, all but one from East Surrey Hospital.

No details were published on the cost of this project, but in South West London Kingston and Richmond Health Authority had calculated that to transfer 2,500 in-patient elective cases to the private sector would require 35 beds and cost £3,000 per case (£7.5m).

By contrast in Merton Sutton and Wandsworth it had been calculated that to keep 82 NHS medical beds open would cost £2.44m. And at St George's Hospital it was calculated that for £5.6m NHS capacity could be increased by 56 beds (28 surgical, 28 medical).

Giving work to private hospitals was a very expensive 'partnership' for the NHS.

The NHS Plan was soon followed by an extension of the PFI principle to primary care, with the establishment of 'NHS LIFT' to fund the building of new surgeries and health centres, leasing them to GPs and Primary Care Trusts. While Milburn argued that this meant a £1 billion investment, in fact only £195m was government funding, the remainder coming from private sector sources seeking hefty interest rates and commitments that future projects in the area would also be financed through LIFT. The plan was opposed by UNISON and campaigners, but forged ahead regardless, although not on the scale anticipated by ministers.

By 2002 the New Labour project was widening to include plans to "franchise" the management of failing trusts to private management consultants, which ended up with a disastrous experiment with management consultants Tribal Secta taking over control of Good Hope Hospital in Sutton Coldfield in 2003.

Franchise failure

Tribal's press release predicted that "Good Hope should become the flagship for building a true private/public sector partnership approach to improving performance within the NHS… Ideally we want to reach a position where franchise support will no longer be required, and it can be 'handed back' to the trust's management team in a stronger, more successful position."

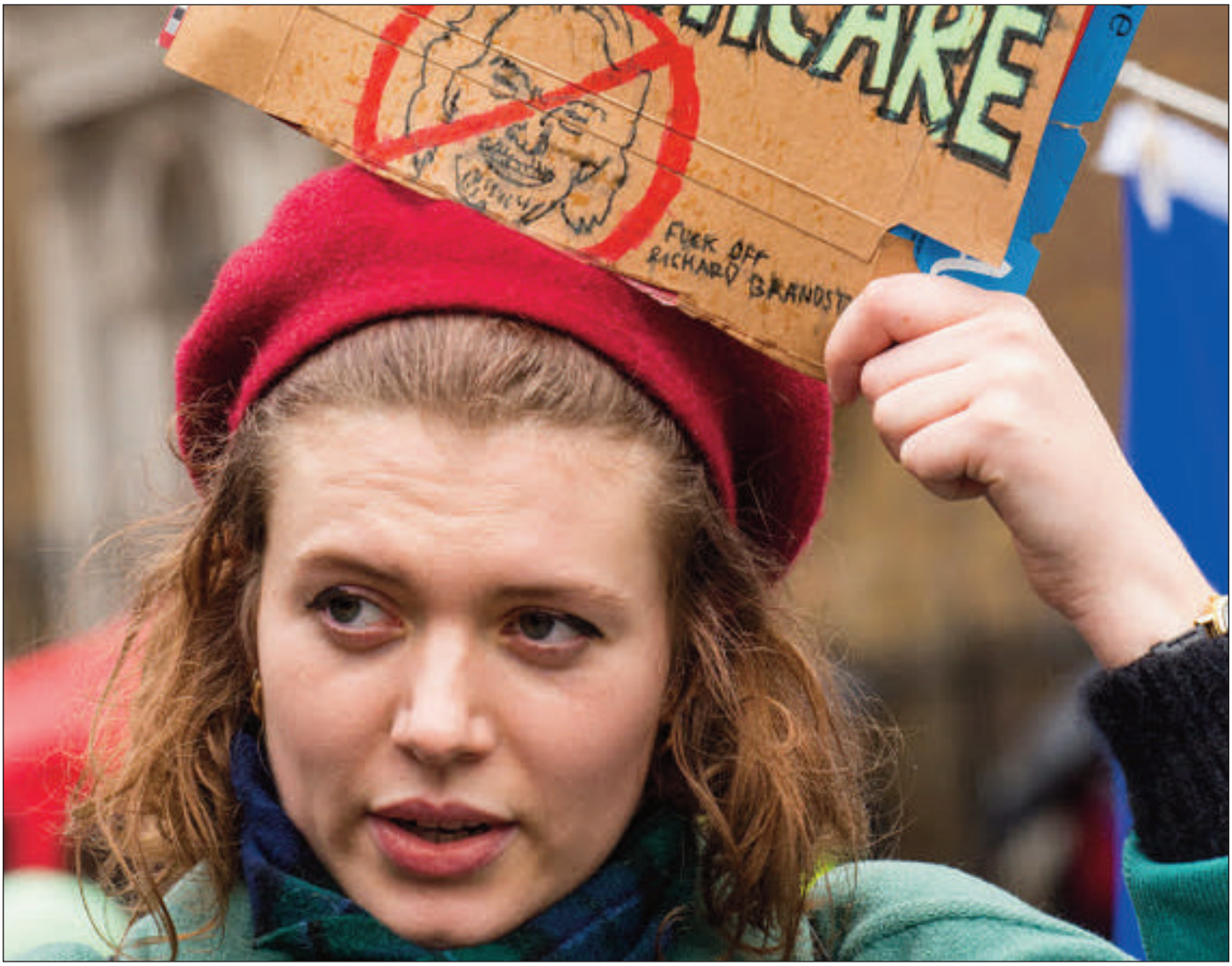
In fact Tribal undermined and weakened the existing management, ran up huge deficits, and eventually had to be bought out early in 2005 before they did more damage. The running of the hospital was handed back to the NHS (Birmingham Heartlands Hospital Trust).

Tribal successfully jacked up their own fees by 48 per cent in its first year – with the Tribal-supplied Chief Executive paid £225,000 per annum, well above the standard rate – while the Trust was reduced to dire financial straits, losing money at £1 million per month.

A 2006 Audit Commission report on the franchise agreement revealed a managerial shambles, with no financial strategy in place, and branded the it as a costly failure. Flaws in the contract even meant the trust itself could not terminate it early or enforce penalty clauses.

Shortly after the deal ended radical cost-cutting measures – closing beds, wards and buildings, to make potential savings of £21 million a year – were needed to prevent a deficit of up to £47.5 million the following year.

All this was clearly lost on New Labour health minister Ben



Bradshaw, who flatly denied that the contract had been a failure.

Nonetheless it was not until the experiment with privatised management at Hinchingbrooke Hospital was signed off by the Cameron government years later that the idea was tested again … to fail once more.

2002 also brought plans to allow the best-performing trusts to opt out of NHS structures to become "Foundation Trusts" (FTs). A furious campaign began against the plan, backed by campaigners, health unions, the BMA and former Labour ministers, which culminated in battles in the Commons and House of Lords.

Although only 63 Labour MPs voted against legislation to establish FTs (while the Tories abstained), the autumn of 2003 saw the policy roundly defeated at Labour Conference – and the scale of the opposition did substantially blunt the edge of Milburn's initial plan.

FTs were at first intended to give wide new powers and privileges to ten or a dozen of the country's top-rated 'three-star' NHS hospitals, although this was soon extended to lesser two-star trusts.

Former health secretary Frank Dobson and other former ministers correctly attacked the plan as a return to the type of market-style methods wheeled in by Margaret Thatcher's government in the early 1990s, and which New Labour ministers was supposed to have swept away after 1997.

They pointed out that the new "freedoms" to be granted to FTs could only be at the expense of other NHS Trusts that were been excluded from the elite status. For example the initial plan was for FTs to be given extra freedoms to borrow, including from the private sector – but their borrowing would count against the total cash limits on the NHS, leaving other Trusts LESS capital for maintenance or new building.

FTs would be free to retain any cash raised from the sale of Trust property assets, prompting fears that some may embark on a new round of asset-stripping; Milburn had to add in a "lock" on NHS assets. They would also be free to set up private companies that offered managerial and other services inside or outside the

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NHS and which could bid to run neighbouring 'failing' Trusts under the government's franchising scheme.

They would have freedom to vary the pay of their staff, giving scope in some areas to offer more to recruit staff with particular skills – subject only to vague restrictions on 'poaching' staff from other Trusts. And they would even be given a guarantee of independence from legal direction by the Secretary of State – raising serious questions over the extent to which they could be prevented from using these other freedoms in ways which threaten the survival of other Trusts.

Capping private patient income

However Milburn swiftly retreated from those warning that FTs would (like the first wave NHS Trusts in the Tory reforms) seek to expand their treatment of private patients and numbers of private beds. He insisted that they would be prevented from doing so, and eventually he was forced to agree to a cap on private patient income – locking FTs in to making no more than their pre FT proportion of income, meaning growth could only come by also growing NHS work.

Milburn insisted Foundations would remain "part of the NHS", controlled by 'stakeholder' members from the local community, who would elect representatives to comprise a majority of a Board of Governors.

He was keen to divert attention away from the experience of the first foundation-style hospital experiment in Sweden, where a major hospital in Stockholm was privatised by its board in 1999 – against the wishes of the local authority and the government.

Campaigners responded arguing the real power would remain in the hands of an unelected management board, and the extent to which 'stakeholder' groups would be representative of the ethnic and social mix of the communities they cover was questionable.

Nevertheless some of Milburn's colleagues, such as Ian McCartney, even argued that Foundation Trusts – supported as they were by the Tory Party and Thatcherite organisations such as the Institute of Directors and the Adam Smith Institute – somehow represented "popular socialism" and harked back to the "old Labour", "socialist" values of "mutualism" and the cooperative movement.

Eventually the amended legislation was forced through the Commons with a majority of just 17.

The real dynamics unleashed by FTs was revealed later on by the Foundation Trust Network, which soon began arguing for an even greater separation from the NHS.

By 2005 they were demanding greater autonomy from government targets, a 'hands off' approach by the regulator (Monitor), the right to provide primary care services, removal of the cap on the number of private patients they were allowed to treat, and to be allowed to "develop a reach beyond health." The Network even argued that patients' needs could be met by adopting "the Debenhams model of providing branded boutiques."

John Lister

Next instalment: 2004-2008, including the spread of private Treatment Centres, "payment by results," the launch of Keep Our NHS Public – and lots more.

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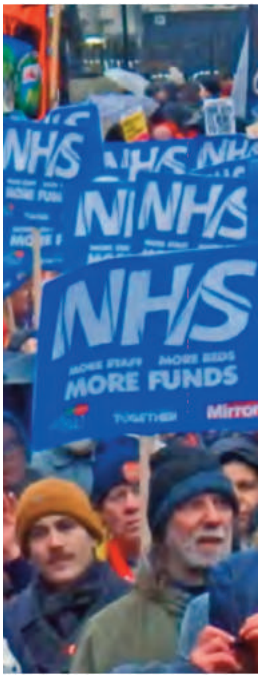

We know many readers are willing to make a contribution, but have not yet done so. With many of the committees and meetings that might have voted us a donation now suspended because of the virus, we are now asking those who can to give as much as you can afford.

We suggest £5 per month or £50 per year for individuals, and hopefully at least £20 per month or £200 per year for organisations. If you can give us more, please do.

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