The lowdown

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

Urgent calls to fix 'incoherent' health and social care staffing

A build-up in staff shortages in both the NHS and social care due to mistakes made over the previous decade by the Conservative government has now led to such high levels of burn-out rates and staff turnover that the services are in danger of not working properly, a cross-party committee of MPs has been told.

The burn-out resulting from chronic workplace stress results in some to take time off sick, others to reduce their working hours, resign or take early retirement, which in turn makes the situation worse for those left.

Dr David Wrigley, the British Medical Association's wellbeing lead, told the Health and Social Care select committee: "Health and care staff suffered stress and work-related anxiety before the pandemic but it is now

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far more serious and we believe the current level of staff burnout and stress presents a worrying risk to the future functioning of the health and care system and safe patient care."

Burn-out is a widespread reality in today's NHS, noted the committee; burn-out damages the health of staff, and affects care safety and quality. It is linked with high turnover and intention to quit, along with higher levels of patient mortality in the acute sector.

A major driver of burn-out is "chronic excessive workload" and the key to tackling it is having the right number of people, with the right mix of skills across both the NHS and care system – good workforce planning.

Set to get worse

The committee was told that there were an estimated 85,000 vacancies in the NHS in England and 112,000 unfilled posts in social care before the pandemic struck. All predictions show that this is set to get worse:

The Health Foundation has predicted that the NHS in England is likely to require workforce growth of 3.2% a year over the next 15 years, which "implies a requirement of a projected 179,000 additional FTE staff by 2023–24, rising to 639,000 additional FTE staff by 2033/34".

The health thinktank The King's Fund told the committee the current approach to workforce planning, was "incoherent" and that funding for education and training was "inadequate" with a "reliance on overseas recruitment".

In written evidence the King's Fund noted that since the 2012 Health and Social Care Act responsibilities for workforce planning had been fragmented and there has been "a lack of clarity" at a national level.

More recently a number of policy decisions (on, for example, immigration, English language testing and student bursaries) made "improvement harder rather than easier."

The Government has for many years based workforce planning on the funds available rather than on the demand and the capacity needed to cope with that demand. This has been a fundamental error that has led to the high number of vacancies.

The Royal College of Nursing is warning that NHS trusts are now recruiting people without the right qualifications to act as registered nurses, despite the risk to patients; another outcome of poor workforce planning over the past decade that has left the country with a shortage of nurses.

"Filling registered nurse vacancies with those who are not registered nurses is not filling those vacancies," said RCN Acting General Secretary & Chief Executive Pat Cullen. "Acting in this way not only leads to vacancies elsewhere but also carries a risk to patient care."

Although using a deeply flawed approach, long-term workforce planning has at least been attempted in the NHS, the latest being the June 2019, the Interim NHS People Plan, in social care there has been no such approach.

The social care workforce is "if anything even more fragile than the NHS" the King's Fund told the Committee. The staff turnover rate was estimated to be 30.8% by the organisation Skills for Care in 2018/19. Skills for Care estimates that if the adult social care workforce grows at the same rate as the projected number of people aged 65 and over in the population, then the number of adult social care jobs will increase by 32% (or by 520,000 jobs), to around 2.17 million jobs by 2035.

What is now urgently needed, the committee concluded, is a comprehensive 10-year plan for social care, however the committee noted that it had called for such a plan from the government previously, as has the Care Quality Commission (CQC), and those in the private and voluntary sector of social care, all to no avail.

Lack of funding

In his oral evidence to the committee Professor Martin Green of Care England, called for a 10- year plan for social care that was "aligned on every level" with the NHS People Plan and included workforce issues, skills mix, support for staff and how to ensure that "we retain as well as recruit the right people".

For both the NHS People Plan and, if forthcoming a plan for social care, it was made very clear to the committee, that however ambitious the plans to address workforce issues are, nothing will come of them unless they are funded sufficiently.

The most recent NHS People Plan was widely criticised for the lack of detail and the lack of funding attached to the plan. The King's Fund described the People Plan as "another stop-gap that falls a long way short of the workforce strategy needed", and the NHS Confederation said that "too many investment decisions have been postponed or clarity has not been forthcoming, especially with the longstanding need to address vacancies".

Sylvia Davidson

No answers on delayed Leamington Spa 'mega lab'

A total, constipated silence from the NHS and ministers shrouds the long-delayed new "mega lab" that was supposed to have opened in Leamington Spa last January as part of the £37 billion 'test and trace' system.

The Department for Health and Social Care has stonewalled – or given misleading answers to questions from local journalists, and Matt Hancock has flatly refused to answer parliamentary questions raised by local MP Matt Western, who has subsequently raised his concerns in the local press, warning that:

"This is a scandal waiting to happen. I have heard from distressed residents waiting months to start jobs, many completely without income. I have heard from scientists who fear lack of regulation, poorly qualified staff and mismanagement at the facility.

"I have heard from NHS groups who are concerned about the undercutting of existing services, 'stealth privatisation' and outsourcing of vital healthcare assets. Yet the DHSC has ignored letters, emails and questions from the media – which is unacceptable and keeps the public in the dark.

Last December then Test and Trace boss Dido Harding let slip that the mega-lab would be run by a private company, Medacs, with no expertise in medical science or laboratories. Medacs is a subsidiary of the multinational Impellam Group, chaired by former Conservative Party deputy chair and tax exile Lord Ashcroft.

'Publicly owned and operated'?

In January The Lowdown reported the lab scientists' professional body, the Institute of Biomedical Science, warning:

"It is vital that these labs have an appropriate skill mix and include significant numbers of HCPC 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"?

"We have professional registration in place for a reason – to protect the public."

By March it was clear that some staff were also being recruited by Sodexo on fixed term contracts to work in the megalab, making no mention of NHS terms and conditions, NHS Pensions, or UKAS accreditation.

Nonetheless the Department of Health and Social Care's response to a question from Matt Western insisted that the "mega-lab" would be "publicly owned and operated," There was no explanation of why the new lab could not be run, and staff employed, by the neighbouring University Hospital of Coventry and Warwickshire.

Since then the opening has been postponed to "spring" – or questions of when it might open simply ignored. Dozens of local residents who have signed contracts to begin working at the laboratory have been complaining to Matt Western that they have heard nothing from recruiters – and been left in limbo, without pay. Some say they have been directed to sign non-disclosure agreements.

Now another local newspaper, the Leamington Courier has interviewed one of these employees, who wishes to remain anonymous but who insists that, contrary to assurances from the DHSC, the lab and its staff will be outside the NHS, and that people on universal credit are being recruited to a specific "trainee lab technician" role. They also now expect not to start work until the autumn "if I even start work at all".

"I have confirmation via e-mail from a staff member at Blue Arrow (who along with MEDACS is recruiting the staff) that I will not get an NHS pension or any other benefits relating to working with the NHS."

The DHSC in statements to the local press has claimed that 200 staff are employed and working at the lab – and that it will eventually create 1,800 jobs.

However the secrecy, the obvious role of private contractors in recruiting the staff, the decision to keep the mega-lab separate from the local NHS and the bypassing of the professional body and the trade unions gives real grounds for concern that another privatised fiasco is under way.

John Lister

GPDPR – a rash dash for data

Unlike the widely touted (and now delayed) date for lifting all remaining lockdown restrictions, the deadline for patients to opt out of a new central database of medical records held by GPs went largely unnoticed before campaign groups and journalists picked up on the story.

Details of the data grab – scheduled for 1 July but now pushed back to 1 September – were last month quietly unveiled online and in a leaflet distributed solely in GP surgeries. This is in sharp contrast to the similar but much less ambitious care.data scheme – launched in 2013 but abandoned just three years later – which saw every household in England receive a leaflet about those proposals.

Described by NHS Digital (NHSD) simply as an "improved collection" service which has been welcomed by "respected voices" across the health sector, the latest data grab – known as the General Practice Data for Planning and Research (GPDPR) service and representing a 'scrape' of 55m patients' medical histories – is being presented as an essential upgrade of the existing GP Extraction Service to help the NHS cope with the demands of the pandemic and beyond, and builds on an arrangement already in place that was introduced last

year under emergency covid legislation.

But although NHSD claims the new service, allegedly in development for three years, has "been designed to the most rigorous privacy and security standards", its low-key launch – combined with the current government's now-default 'nothing to see here' stance on most things – has inevitably set alarm bells ringing.

Concerns centre primarily on how much data will be shared. NHSD claims it will not be hoovering up patients' names and addresses, and that all other data (including diagnoses, symptoms, referrals and information on sex, ethnicity and sexual orientation) from GP records will be 'pseudonymised' – using de-identification software to create unique codes – before being shared.

Lack of clarity

However, NHSD admits it could use the same software to convert those codes back to data that could then directly identify patients "in certain circumstances". What those circumstances might be are unclear.

And who might access this patient data in the future, and for what purpose, is also hard to pin down.

NHSD already runs a data access request service (DAR) for commercial interests hungry for health service data, and although the accompanying website claims that data cannot be used purely for commercial purposes, and that marketing and insurance firms are unlikely to be granted access, historically the evidence does not inspire confidence.

Private Eye noted this week that in 2014 a government review of NHS data releases found two instances where the recipient was not even recorded, and three instances of material being released to insurance companies.

The DAR website highlights the input of one successful recent applicant – global management consultancy McKinsey – using a case study looking at its work on two hospital contracts.

This is the same company that, according to news site Digital Health last year, was awarded an NHS Test & Trace contract by the Department of Health & Social Care under which it could potentially be granted access to personal data including names and addresses, as well as biometric and medical data, for up to seven years.

With another US firm, data giant Palantir, already working on the health service's covid 'datastore' platform – elements of which may or may not have informed the launch of GPDPR – it's understandable that the medical profession has concerns over the rushed introduction of the new service and the lack of public awareness of its implications.

The British Medical Association and the Royal College of General Practitioners – both of which NHSD claims to have consulted before unveiling the GPDPR service in May – have urged NHSD to improve its communication efforts relating to the new service, which they have deemed "completely inadequate", confusing patients and GPs alike during the pandemic.

And in early June 36 GP surgeries in east London agreed to withhold the requested data when collection was due to begin on 1 July.

Shared GP data has nevertheless been used to good effect during the pandemic, for example helping to identify dexamethasone as an effective treatment for covid patients during the Recovery trial, set up as part of the NHS Digitrials programme, jointly run by Oxford University's Big Data Institute, IBM and Microsoft.

Limits imposed on GP data sharing, conversely, are claimed to be holding back research into a range of conditions such as dementia, arthritis, heart failure and depression, according to a joint statement released on behalf of 120 medical researchers by Health Data Research UK, shortly after the GPDPR delay was announced.

Despite that missed potential, the backlash from professional bodies and privacy groups against the GPDPR service is certainly having an impact, with around 1.5m people indicating they want to opt out of the new programme.

Scheme could be hit by opt-outs

This has led NHSD's interim chief executive Simon Bolton to warn the service will be rendered less effective the more people drop out, or if people opting out are disproportionately from a specific group.

It may also be behind health secretary Matt Hancock's unexpected drafting in of Government Statistical Service chief Sir Ian Diamond and Academy of Medical Royal Colleges chair Helen Stokes-Lampard to bolster the GPDPR programme ahead of its September relaunch – a date campaigners still consider far too soon to ensure informed consent.

Martin Shelley

Patients now have until 25 August to opt out of the new GPDPR service. For more information, please visit https://medconfidential.org/how-to-opt-out/

Ministers complacent as hospital trusts struggle with emergencies and waiting lists

NHS hospitals are under the cosh as they face a rising tide of emergency attendances with a reduced number of front-line beds available, a significant continuing need for beds to treat Covid-19 patients as infection rates increase – and the challenge of tackling the growing backlog of waiting list patients that worsened during the pandemic.

NHS figures analysed by the Health Service Journal show a third of acute trusts (49/145) were operating at 95% or higher levels of occupancy last month with numbers of emergency patients higher than any time since the winter before the pandemic.

However the occupancy rates relate to the reduced numbers of front-line beds, which fell rapidly during 2020 as beds were closed or removed from wards to increase social distancing and reduce dangers of infection.

The HSJ calculates that the average number of acute beds not reserved or in use for Covid patients fell to 89,339 in May, down by over 12,000 from the numbers that had been available at the same time in the last few years before Covid.

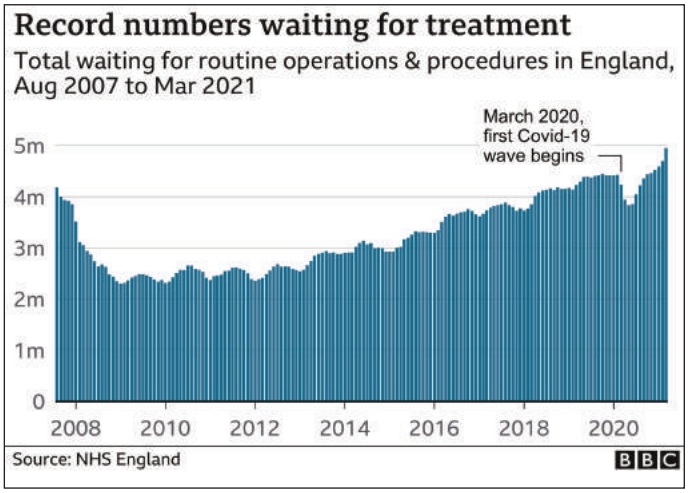
The most recent published quarterly bed figures for the three months to March 31 show 96,000 beds available in England, of which just under 80,000 were occupied, compared with 102,000 beds open and over 90,000 occupied in the same quarter a year earlier.

Problems pre-date covid-19

In other words NHS capacity is still hobbled by the aftermath of Covid, the lack of capital to remodel and refurbish hospital buildings to make most effective use of space, and the lack of staff with high post-Covid sickness levels adding to chronically high levels of unfilled posts – while some of the patients who opted

to stay away from seeking hospital treatment during the peak of the pandemic are now being referred by GPs or arriving as serious emergencies. However a look at the time series for waiting list figures shows that the major increase in numbers waiting took place BEFORE the Covid pandemic: indeed the numbers waiting initially fell in the early part of 2020 before rising again more sharply in more recent months as the toll of Covid patients and the lockdown have eased.

The latest figures show numbers waiting have risen by 425,000 in the past two months to a record 5.1 million, more than double the number when David Cameron's government took office in 2010 and imposed a decade of austerity and frozen funding on the NHS.



Two-year waiting lists

Indeed while the most recent figures show some of those waiting over 1 year for treatment have finally had their operations to slightly reduce that total, a worrying 2,722 are currently waiting over TWO years for treatment – a figure that had been eliminated from statistics by the decade of above inflation increases in NHS spending from 2000.

However according to a Guardian report, Boris Johnson is not willing to spend the extra money needed now to prevent a further proliferation of long waits because not enough patients are yet aware of the scale of the problem and complaining to MPs (or to put it in cynical Downing Street terms "the public are not yet 'distressed' about the long delays."

The Health Foundation has calculated that to bring down the backlog of cases and meet the target of treating 92% of patients within 18 weeks of referral (which has not been achieved for 5 years) the NHS would need to spend an extra £6bn per year over three years: apparently Downing Street has estimated that the costs of bringing down the waiting times could be more than twice as high – as much as £40 billion over 4 years.

NHS Providers Chief Executive Chris Hopson has even begun pointing out that the key to bringing down waiting lists in the 2000s to a maximum 18 weeks was the "five years of 7%+ real terms increase in annual NHS funding" – in stark contrast to ministers' meaningless boasting about much smaller cash increases.

The Health Foundation's estimates are based on the need to open 5,000 extra beds, and employ 4,100 more consultants and 17,100 more nurses. The King's Fund also points to England's chronically low level of provision of scanners and lack of operating theatres as obstacles.

While conjuring up extra staff is a major problem – especially after the government's derisory offer of a 1% pay increase – the latest figures show that thousands of extra NHS beds already exist – in hospitals that cannot fully use them without investment to reorganise clinical areas.

Instead of making a serious estimate of how much capital investment is needed to get the NHS working at the level required, the Johnson government has agreed for NHS England to divert up to £10 billion over the next 4 years on stop-gap measures to use private hospitals to treat NHS patients. This will drain funds and vital staff from over-stretched NHS hospitals.

The entire capacity of the private hospital sector is just 8,000 acute beds – and many of these are now being used for private patients as the private sector cashes in on the growing delays accessing NHS care. So there is no way at all the deal with private hospitals can compensate from the 12,000 fewer beds available in the NHS.

Risk of dependence on private sector

As The Lowdown and Health Campaigns Together have warned, in four years' time if present policies continue the NHS will still be unable to use its full capacity, and will have become permanently dependent on private hospitals to deliver substantial levels of elective treatment.

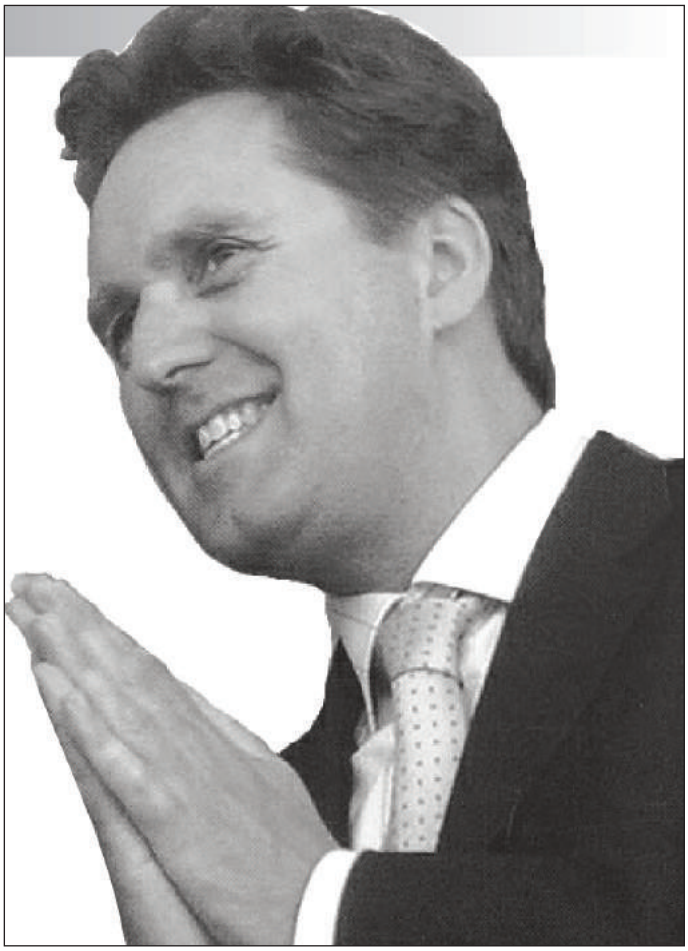
The big question is whether ministers will be allowed to rest secure from public anger over such a major and long-running failure of the NHS which Johnson professed to love so much in the 2019 Manifesto.

In the mid 1980s Margaret Thatcher attempted to tough out public anger over widespread delays of 18 months and more – but in the immediate aftermath of the 1987 general election came under sustained fire from right wing national press as well as local news media as stories broke of cancer patients and children with heart disease dying on waiting lists.

Even the Iron Lady was obliged to bend to the pressure for action and increased funding: sustained campaigning at local and national level could yet force the Tin Man to do the same.

John Lister

History of NHS privatisation, part 6: NHS money commissions new private hospitals



By 2004 New Labour reforms were so far-reaching they appeared to threaten to reduce the NHS to little more than a "brand name", a centralised fund commissioning and paying for patient care.

The model seemed to be a tax-funded version of the "sickness funds" of European social insurance-based systems: that could reduce NHS hospitals to providing care for emergencies and the chronic sick, while competing on ever less favourable terms with private sector companies for a share of the budget for elective services – and for the staff needed to sustain basic health care.

Back in 2002 a new policy statement from the Secretary of State Alan Milburn, Delivering the NHS Plan, had argued that "the 1948 model is simply inadequate for today's needs":

"We believe it is time to move beyond the 1940s monolithic, top-down centralised NHS towards a devolved health service, offering wider choice and greater diversity bound together by common standards, tough inspection and NHS values"

A 'mixed economy'

By 2004 Tony Blair's former advisor on NHS policy, Simon Stevens, ten years later of course to be NHS England chief executive, was setting out a full-scale scenario for a 'mixed economy' in health:

"Government is now stimulating a more mixed economy on the supply side, to expand capacity, enhance contestability, and offer choice. Free standing surgical centres run by international private operators under contract to the NHS are a first step. Private diagnostics and primary care 'out of hours' services are next".

However some of the harsh reality of privatisation and competitive tendering was also beginning to hit home.

In 2004 the Department of Health itself explicitly recognised the link between competitive tendering and the falling quality of what remain labour-intensive services. Its document Revised Guidance on Contracting for Cleaning noted:

"Following the introduction of compulsory competitive tendering, budgets for non-clinical services such as cleaning came under increasing pressure, and too often the final decision on the selection of the cleaning service provider was made on the basis of cost with insufficient weight being placed on quality outcomes.

"Since NHS service providers were in competition with private contractors, they too were compelled to keep their bids low in order to compete. The net effect of this was that budgets and therefore standards were vulnerable to being driven down over an extended period until, in some cases, they reached unacceptable levels.

"… there remains concern that price is still the main determinant in contractor selection."

In October 2004, then Health Secretary John Reid argued that one reason for the proliferation of one of the most serious HAIs, methicillin resistant staphylococcus aureus (MRSA) had been the Tory government's decision to contract out cleaning work, with contracts going to the lowest tender.

A survey showed that while just over a third (440 of the 1184

hospitals surveyed) employed private contractors, 15 of the 24 hospitals deemed "poor" were cleaned by private contractors. This suggested very clearly that the incidence of poor cleaning was twice as common among privatised contracts.

However these lessons were not applied to other services that were still being energetically contracted out.

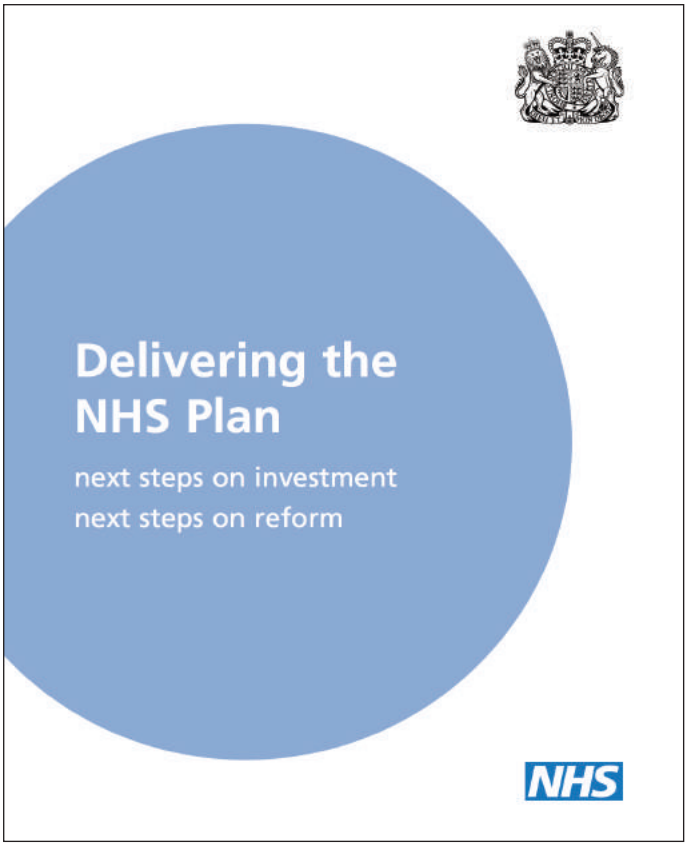
One of the most decisive areas for contracting out was elective surgery – as new Labour went much further than Thatcher had dared, and began to outsource clinical care.

In 2003-4 ministers were driving the establishment of 'Independent Sector Treatment Centres' (ISTCs), the coy New Labour-speak for a chain of 26 privately-owned and run units previously known as Diagnostic and Treatment Centres (DTCs).

20 NHS-run DTCs had been quietly established and were on course to operate successfully.

But the kernel of New Labour's plan was to allocate a substantial share of routine NHS elective surgical and diagnostic work to the private sector –the same private sector that routinely poached NHS-trained nursing and medical staff, and which cherry picked the patients and the procedures which offered the most profits, leaving all of the costly, long term and intensive treatment to the NHS.

After the 'Concordat', which proposed a greater use of private hospitals to treat NHS-funded patients, the ISTCs were to be different: they were to be new units, set up and run from the outset by the private sector.



Under the original specification, they were supposed to make no demands on the local pool of qualified health workers, but bring all of the necessary staff with them: so many of the corporations submitting the first bids were overseas or multinational companies.

According to the Department of Health document Growing Capacity the ISTCs were supposed to ensure 'additional clinical activity, additional workforce, productivity improvements, focusing specifically on additional capacity':

"It will be a contractual requirement for providers to define and operate a workforce plan that makes available additional staff over and above those available to the NHS."

In fact none of this happened.

The rise of 'contestability'

By autumn 2003 ISTCs had been told that they were free to recruit up to 70% of their workforce from the NHS, potentially stripping local hospitals of staff, and lumbering them with sky-high bills for agency staff to fill the gaps.

Creating a brand new element of the private sector was argued by New labour advisors and ministers as a vital step to create "contestability" – the coy phrase for competition, which New Labour was even more committed to as a principle than Margaret Thatcher had been. Ministers were convinced competition would drive trusts to cut costs and improve quality – while all it achieved was diverting hundreds of millions out of NHS budgets into private pockets.

NHS Trusts and Foundation Trusts increasingly had to compete not only against other NHS providers, but also against private hospitals which had a much less complex and costly caseload.

But the competition was even more unfair than this suggests: ISTC contracts were ring-fenced … so that only private sector providers are allowed to bid for them!

The profit-seeking ISTCs would each scoop up a share of the projected 250,000 procedures a year to be diverted from existing NHS units.

The nationally-negotiated contracts were on a 'play or pay' basis, meaning that the PCTs were required to pay the full contract price to the ISTCs over the 5-year period, even if the NHS sent fewer patients for treatment.

Of the preferred bidders announced in September, five were from overseas – Canada, South Africa and the USA – and two British. They were contracted to treat only non-urgent cases where waiting times were a problem, including orthopaedics (hip and knee replacements), ophthalmology (mainly removal of cataracts) and minor general surgery such as hernia and gall bladder removal.

The private units had no obligation to after-care: and they could fix their own terms and conditions, with some offering consultants four or five times what they'd get from the NHS.

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While Ministers claimed ISTCs would be paid the same cost per case as NHS hospitals, in practice they took on only the simplest and cheapest cases, leaving the NHS with an increasingly expensive caseload. Even the ISTCs' start-up costs were subsidised.

It was also later revealed that the average ISTC treatment incurred an additional cost of 11.2% above NHS levels – meaning that for every nine ISTC patients NHS hospitals could have treated ten. Their profits were guaranteed.

While in NHS units such as the Oxford Eye Hospital the revenue from cataract operations helped underwrite the running costs of a department delivering a full range of services, any surplus created by DTCs would simply be pocketed as profit by shareholders.

The opposition to the plans was widespread.

Private hospital chiefs were miffed that new units are being built instead of filling up their existing empty beds. Tory shadow health minister Liam Fox said the contracts were too expensive.

UNISON warned that they would drain resources and staff from the NHS. The BMA said ISTCs could destabilise the NHS. Even the Royal College of Nursing expressed concern over staffing levels.

To make matters worse, establishment of ISTCs came after an injection of new funds into the NHS to enable it to expand its own capacity. Just as some of these investments were starting to deliver, a small group of bureaucrats at national level decided where the new ISTCs were to be.

Only bankrupt Bristol PCTs were allowed to refuse an ISTC: other local health commissioners were given no say, while the PCTs in Oxfordshire that objected to an ISTC for ophthalmic services were roughly slapped down.

Problems? No comment

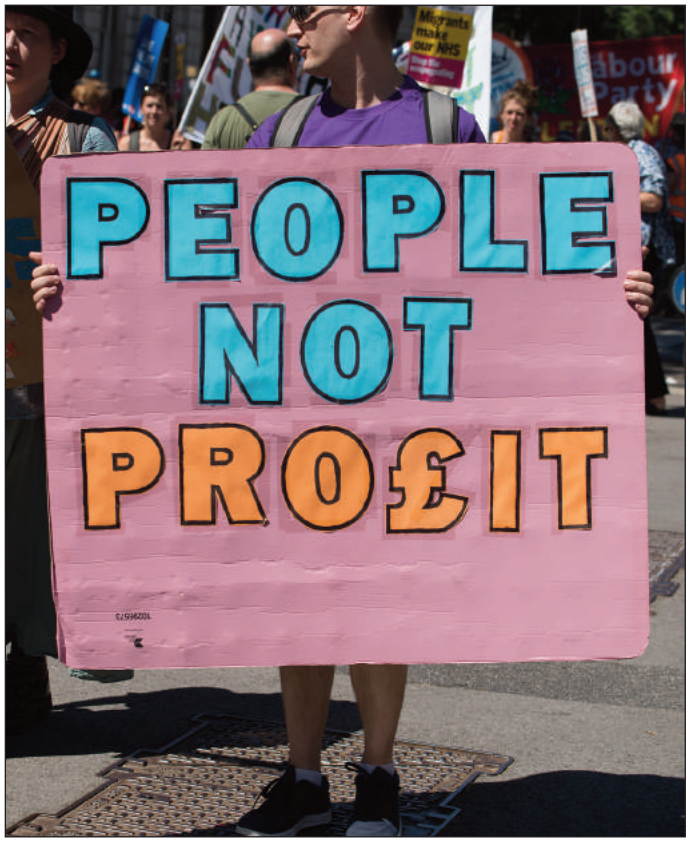
Meanwhile in autumn 2004 the extent of the autonomy on offer to Foundation Trusts (see previous article in this series) was thrown into question, when Bradford Hospitals FT found itself facing a substantial deficit (predicting a £4 million deficit after just six months).

This level of deficit was modest compared with the crisis situation then developing in many NHS Trusts, but the regulator Monitor immediately intervened – by calling in a firm of New York-based business trouble-shooters to sort out the trust.

The company, Alvarez & Marsal, was chosen and called in by Monitor: but the costs of flying in the team of "turnaround management consultants" (who had to be told that British healthcare is priced in pounds and not dollars) had to be paid by the Bradford Trust.

The recipe for turning around included axing sandwich snacks for elderly patients and security guards on the hospital car park.

Ministers predictably washed their hands of the whole business. In the House of Commons Health Secretary John Reid is-



sued a statement refusing to answer parliamentary questions on any foundation trusts, declaring that:

"Ministers are no longer in a position to comment on, or provide information about, the detail of operational management within such Trusts. Any such questions will be referred to the relevant Trust chairman."

Nonetheless in the 2005 General Election: the Blair government made it clear that if they were re-elected then all hospitals would be pressed to become Foundations.

As a vital part of its new, wider-reaching marketising measures, New Labour also moved to introduce a much more complex system for financing health care providers.

The most important change was originally described in the NHS Plan as "reforming financial flows," but became known (misleadingly) as "payment by results" (PBR).

In fact the payments had nothing to do with the "results" of the treatment: the hospital secured the same fee whether the patient jogged out in a tracksuit or was carried out in a box.

PBR is a 'cost-per-case' system, linked to a fixed national tariff of "reference costs" for each item of treatment they deliver. The new system was introduced firstly for Foundation Trusts in 2004, and later rolled out across other acute hospital Trusts.

The new structure was designed with two prime objectives:

to create a new framework within which Foundation Trusts could secure a wider share of the available contract revenue in a

competitive health "market", while Trusts less well resourced, or whose costs for whatever reason are higher than the reference price, could lose out.

and to open up a portal through which NHS funds could be extracted to purchase care from private providers such as ISTCs.

By effectively commodifying health care at such a basic level, the PBR system fitted the New Labour objective of breaking down the barriers between the public and private sectors, and ensured that every NHS patient who chose (or was persuaded to accept) treatment in an ISTC or private hospital took the money with them … out of the NHS.

So the crisis and cash shortfalls remained within the NHS, while the private sector collected a guaranteed margin.

Ministers attempted to create the illusion that the situation was being driven not by them but by patients: individual patients were offered a progressively wider "choice" of where they wanted to have their treatment.

By the end of 2005 Primary Care Trusts were obliged to offer almost all patients a "choice" of providers – including at least one private hospital – from the time they were first referred. By 2008, the NHS's 60th year, any patient was allowed to choose any hospital which could deliver treatment at the NHS reference cost.

New Labour ministers made clear that they wanted at least 10% of NHS elective operations to be carried out by the private sector in 2006, rising to 15% by 2008.

This policy was strongly criticised, not least by the BMA, but also by studies produced by London NHS managers for Health Secretary John Reid, which warned that the plans were "problematic, unaffordable" and of "no benefit" in London, since they would have serious impact on the financial stability and viability of NHS Trusts.

The Commons Public Accounts Committee pointed out the obvious danger that the policy could result in private sector providers "cream skimming" the most straightforward and lucrative cases, leaving NHS hospitals with reduced resources to cope with the chronic, the complex and the costly patients.

There was growing concern that hospitals which lost out as patients chose to go elsewhere could be forced to close departments – or close down altogether: ministers and senior NHS officials said that they were willing to see this happen, arguing that it would not be their policy, but patients who made the decision.

But the new system also represented the end of 30 years of efforts to equalise allocations of NHS spending on the basis of population and local health needs: the new market system emerged as the enemy of equality.

The prospect of widespread financial instability forced a delay and a phased introduction of the new payment system, which was to have applied to 70% of treatments by April 2005, but which by the time of the General Election had already been postponed by 12 months.

John Lister

Health visitors being cut in Staffordshire

Nurses and health visitors in Staffordshire could lose their jobs due to council budget cuts, Unite officials are warning.

Staffordshire County Council is moving ahead with £2.5 million of cuts to its children and young people's health and wellbeing services, a decision made by the council three years ago.

The plan is for the number of health visitors to be reduced by seven whole time equivalents (WTE) from 42 to 35. Unite estimates that each health visitor has responsibility for about 400 families, so if seven health visitor jobs were lost, up to 3,000 families could be adversely affected.

Services are being redesigned and a new Children and Young People's Health and Wellbeing Programme, for children and young people aged between 0 to 19 years of age was launched in April across Staffordshire, and combines health visiting and school nursing services into one,

Unite regional officer Frank Keogh said: "This financial 'hit' will further reduce the numbers of health visitors and school nurses and, therefore, leave the community vulnerable. This is at a time when families need support more than ever as the impact of the government's austerity agenda continues to the detriment of children and the services provided to support them.

Alan White, the council's deputy leader and cabinet member for health, care and wellbeing told the nursing TImes: "With less money to go around we do have make every penny count and we will still be spending £9.4m on this new contract which will offer more targeted, additional support to the most vulnerable as well as making the best use of digital technology via advice hubs,"

Frank Keogh added: "These cruel cuts are putting vital services, such as maternal and child mental health, child protection and domestic abuse, under even more severe strain. Recently implemented cuts have already hit hard in Staffordshire with the loss of children's centres and support for breastfeeding."

West Country hospital trust buys private hospital

The Royal United Hospitals Bath Foundation Trust has bought for an undisclosed sum, Circle Bath, a private hospital in Bath owned by Circle Health. The hospital has now been renamed Sulis Hospital Bath.

Circle Health had to sell the hospital under an agreement with the Competition and Mergers Authority following Circle's 2020 acquisition of BMI Healthcare; BMI Healthcare also has a hospital in the city.

The foundation trust said that the move would "secure capacity for NHS patients at a critical time of recovery for NHS waiting lists nationally as well as seeking to increase capacity at the facility for the benefit of all patients – both NHS and private".

Although a private hospital, Circle Bath had always carried out a considerable amount of work for the local NHS trusts.

RUH chief executive Cara Charles-Barks told HSJ that the Circle/BMI acquisition undertakings meant it had to maintain 30% private activity at the site, and that it planned to use the rest for NHS work. The plan is to use the hospital as a separate cold (non-covid) elective surgery site to maintain activity through winter and to develop it as a diagnostic hub for Bath and the wider region.

The Circle Bath hospital itself is relatively small, with only 28 inpatient beds, 22 day case beds and four operating theatres. In 2019, its revenue was just over £24 million but it made a loss of almost £1.9 million, according to filings on Companies House.

The trust funded the purchase itself and now owns 100% of the shares in the hospital operating company, which it will operate as a subsidiary organisation under the same management team. No legal problems have been found, according to Ms Charles-Barks, and the trust has worked closely with NHS England.

The hospital trust has only purchased the hospital operating company, Circle Hospital (Bath) Ltd, not the hospital building and land which is owned by another company and was leased to Circle Health.

The owner of the lease is the US company MPT (Medical Properties Trust), which bought the lease from Circle back in 2014. MPT specialises in owning the leases on hospital/medical facilities, with 58% of its portfolio in the USA and 22% in the UK, its second biggest market; in the UK it owns the leases of 42 hospitals. Income is made from lease payments and other financial transactions with the hospital operating companies.

Sylvia Davidson

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