The lowdown

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

It's high time ministers and the NHS took staffing crisis seriously

The key issue in expanding NHS capacity is staff, and the need for a long-term workforce strategy. Without significant investment, and a willingness to change the way staff are treated and managed, the chronic shortages are only likely to grow – putting patient safety and quality of care at risk.

This was highlighted in a heavy-hitting speech last month in the Lords by Lord Stevens of Birmingham, aka Simon Stevens, no longer constrained by his seven years in charge of NHS England.

Stevens was keen to lay the responsibility firmly for delays and failure at the door of the government and the Treasury, who he argued had time and again blocked the development of any serious workforce plan by failing to guarantee the necessary funding, and prevented discussion of any plans that might cost more. Tracing this right back to his own first year in post, he said:

"It was back in 2014 that the NHS Five Year Forward View talked about the service changes that were required, but it was not permitted to talk about future capital investment, social care or workforce training, since they were being kept separate."

Two years later "in summer 2016, the Department of Health and Social Care was going to produce this detailed quantified workforce plan instead." But that didn't happen:

"instead, in December 2017– three years after the Five Year Forward View – Health Education England launched a consultation document which said: "Your responses will be used to inform the full strategy to be published in July 2018 to coincide with the NHS's 70th birthday."

"Twenty-eighteen came and went, and answers saw we none. Then in June 2019, we got another, in this case interim people plan, with lots of excellent content but unfortunately no actual numbers and no new pound notes."

A full, costed five-year Plan was promised "later this year" but nothing was heard until in July 2020 "we had a one-year people plan which, at that point, was covering just the next eight months," and promising "Further action … to be set out later in the year … "once funding arrangements have been confirmed by the Government."

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But instead, "in July 2021, last summer, the Department of Health and Social Care again commissioned Health Education England to start from scratch."

Whether or not the Lords amend the Health and Care Bill to include a requirement for regular updates and planning of workforce, and whether ministers accept it in the Commons remains to be seen: but there is no evidence in recent statements that ministers have grasped the need for more than empty promises.

On 25 January Sajid Javid told MPs he had "recently" commissioned an NHS workforce strategy: but in the same meeting of the Health and Social Care Committee, its chair Jeremy Hunt reminded Javid that Health Education England, the body charged with deciding how many doctors and health professionals are trained, still does not know how much money they will have from April, as it goes in to a merger with NHS England.

The government's Red Book last October declared that the Spending Review settlement "will keep building a bigger, better trained NHS workforce," and reaffirmed "the government's existing commitments for 50,000 more nurses."

On January 24 Lord Kamall tried to reassure the Lords debate that the government was "on target" to recruit the promised 50,000 nurses.

No funding allocated for extra staff

The facts are very different. No funding has been allocated to pay the £1.5bn per year minimum cost of an additional 50,000 staff. The 50,000 target also included an ambitious number of overseas recruits – and retention of 19,000 existing staff – while anecdotal evidence suggests demoralised and burned-out staff are leaving and overseas recruitment has stalled.

Workforce statistics (September 2021) show nurse numbers up overall by just 11% since July 2010, and midwife numbers by 13%, but health visitor numbers down by 19%. Mental health nurse numbers are also down by 2,350 (5.6%) and falling, despite the promise by Theresa May's government in 2017 that 21,000 new posts would enable mental health trusts to treat an extra million patients a year.

In the last quarter of 2021 a record 27,000 clinical staff voluntarily resigned from the NHS.

The most recent figures, to September 2021, show that there are 99,460 (7.3%) unfilled posts across England's NHS – of which almost 40,000 are nursing posts, with vacancy rates ranging from 7.8% (South West) to 13.1% in London (with higher rates for mental health staff, ranging from 8% in the North West to 14% in London).

They also show only 8,440 nursing and midwifery vacancies were being advertised in September 2021, almost 23% down from 10,944 in September 2020.

The ridiculous decision of Tory MPs to vote down Jeremy Hunt's proposal for two-yearly reviews of staffing levels and workforce plans serves only to underline the yawning gap where there should be a workforce strategy.

This is compounded by the lack of realism in ministers' attempts to hold down NHS pay.

Pay rise needed to reward and retain staff

A substantial across the board fully-funded pay increase for all NHS staff – over and above the 3% 2021 'increase' that has already been swallowed by inflation and increased national insurance payments – is also needed to show hard-pressed and demoralised staff, who are beginning to leave, that they are valued. It would help retain them, recruit new staff – and make it more attractive for qualified staff who have left already to come back and work for the NHS.

Last October Andy Cowper in Health Policy Insight urged an immediate resumption of the work that had been done to get retired clinicians to return to practice, which had been halted "once the first wave of infections in 2020 was not believed to have demonstrably overwhelmed the NHS. That decision was a big and foolish error, and it should be fixed."

And to tackle the dwindling recruitment of EU and other overseas qualified staff to strengthen NHS and social care teams the government has to scrap all limits on overseas recruitment and the counterproductive migrant surcharge and visa fees which spell out a message that foreigners are no longer welcome. The cost of these measures in lost revenue would be minimal and the potential benefits very substantial.

While the extra spending required to resource a serious workforce plan is substantial, it will, as health spending always does, generate other benefits including the creation of more jobs in construction, in health care, and the supporting industries, which in turn will generate economic growth across the country.

But it's not all about pay. With pay in some supermarkets and service industries now outstripping NHS rates, a combination of investment in staff, a zero tolerance crackdown on bullying and harassment and all forms of discrimination, and an investment in staff welfare and wellbeing are also necessary to make the NHS an employer of choice.

Andy Cowper has also called for a renewed effort by

trusts to look after their staff as well as possible. "If organisations have been foolish enough to take out obvious pandemic improvements like free car parking and provision of good access to food, then put them back immediately."

The government has offered only complacency and warm words. Last month Lord Kamall claimed that NHS England had an "intensive retention support programme" in place since 2017, offering "emotional, psychological and practical support for NHS and care staff."

Former Chief Nursing Officer Dame Sarah Mullally boasted that in 2020 £15m funding had pledged to strengthen mental health support for NHS England's (1 million) staff. But despite a further £37m for 2021-22 to enable the continuation of this offer in the pandemic, staff wellbeing remains a serious concern, and the Nursing Times reports many nurses warning that national support has not been good enough.

Despite being pressed on the point Lord Kamall made no commitment to any additional funding for staff wellbeing.

The practical point about availability of food, especially for hard-pressed staff on 12-hour night shifts, is underlined by recent shocking findings of a survey by the Institute of Health and Social Care Management, which found that less than 10% of 250 responses reported that freshly-made hot food was available 24/7 in their trusts, while 38% reported "no food of any type (hot or cold) was available at all."

As a result "streams of fast food delivery companies" mean security staff on nights and weekends were being diverted from their normal duties "to act as concierge for deliveries and contacting ward staff who had placed the orders."

The IHSCM reiterating its support for 24/7 provision of hot food for staff in health and social care, comments: "Whilst the NHS and social care experience severe and consistent workforce recruitment and retention issues it is strange that the issue of hot food availability for staff who may be working long shifts is not taken more seriously."

Little thought for staff wellbeing

Attention to staff wellbeing can help increase staffing levels, improve the quality of patient care, and in so doing improve the morale and job satisfaction of staff, win back the confidence of some patients, and begin to clear waiting lists and rebuild the performance of the NHS after the long dark decade of decline since 2010.

The continued failure to devote serious resources to staff wellbeing especially in such stressful times heads in precisely the opposite direction.

Worst management examples?

The Lowdown recognises that most NHS senior managers have made extraordinary efforts alongside staff before and during the Covid pandemic: but some are clearly detached from the problems faced by staff at the front line – and others are failing to shoulder their responsibility to develop suitable wellbeing support for staff under the greatest stress.

Diane Wake, chief executive of the Dudley Group NHS Foundation Trust, which runs Russells Hall Hospital. She has opted to turn to crowd funding and the hospital's charity to finance what should be basic wellbeing measures.

Charity is no solution

The Birmingham Mail reports the charity has been inviting donations through justgiving.com. The suggestions on how the money might be spent show the Trust want charitable funds to do the sort of things a caring NHS management wanting to retain valued staff should itself be doing. The appeal states:

£5 could cover a hot meal for a frontline staff member who is unable to leave the ward on a twelve-hour shift.

£15 could fund a wellness pack for one of our extremely stretched staff members, particularly those in financial hardship.

£50 could help provide emotional support for a nurse at the end of a gruelling shift.

£10,000 to 20,000 could refurbish a staff room into a wellbeing space where staff can relax, refuel, and recharge as they spend some much-needed time away from clinical areas.

The appeal has so far raised over £210,000 of the £300,000 target. We have no information on whether and how it has been spent.

But the existence of a "fundraising and community development lead" on the staff of the trust, and the call for donations to facilitate what should be the basic work of the NHS as an employer, echoes the desperate Thatcher years in the 1980s in which hospitals were forced to divert management time and effort to "income generation" schemes – and even jumble sales – to keep services going.

What staff need in these new mean, lean times of austerity is a management that recognises their welfare is a management responsibility, rather than hoping a generous public will fork out to fill in the gaps.

If you have evidence of management decisions that are unsupportive to staff send it to us at The Lowdown, with enough information to run a story: we are happy to keep our sources confidential..

John Lister

Please donate to help support our campaigning research and journalism

Will Javid's GP reorganisation meet the challenge of improving access to care?

The primary care sector is set for a major upheaval under new plans to improve patient access, according to a ministerial briefing to the Times.

Details of funding and a timetable for the move are hazy, but it appears to revolve around a 'vertical integration' model which would see GPs widely employed directly by the NHS via hospital trusts – an idea already piloted in Birmingham, Cheshire and Wolverhampton – and effectively abandon the independent contractor model that has been in place since 1948.

A second element of the restructure – the establishment of a 'national vaccination service' to take over the administration of health campaigns such as the annual flu inoculation drive which GP practices are currently paid to manage, could further undermine the role (and finances) of existing local surgeries.

This new initiative from health secretary Sajid Javid follows on from his comments last autumn blaming overloaded and under-resourced A&Es on a perceived lack of GP appointments, which was embraced by various right-leaning media outlets and saw doctors being subjected to physical and verbal abuse from patients.

But despite the Times' attempt to brand Javid's plan as a form of nationalisation that will complement the government's much-hyped 'levelling up' agenda, the report offered no evidence that the restructure will address the main issues facing the sector: declining GP numbers and the poor provision of general practice in deprived areas.

Where are the extra numbers promised?

In terms of numbers, the government has a lamentable record of delivery on its pledges relating to general practice. The health secretary admitted in November that it would not be able to boost GP numbers by the promised figure of 6,000 by 2025, and only last month research by the Royal College of GPs showed that less than 10,000 of the 26,000 extra health professionals pledged three years ago by the government had actually been hired by surgeries.

And if Javid is at all serious about integrating primary care staff into the fabric of the NHS the government's broader workforce

planning record will provide scant comfort for those worried about the long-term impact of his plan, concerns that were amplified after recent parliamentary debates on the Health and Care Bill.

Ministers rejected an amendment to the Bill in November that would have required independent, and more regular, assessments of workforce requirements, while last month former NHS ceo Lord Stevens accused the government of "wilful blindness" on the matter during a debate in the House of Lords, adding, "It is a statement of the blindingly obvious, particularly coming out of the pandemic, to say that we need better workforce planning."

However, the statistics also illustrate the pressures on the existing practice model that Javid is seeking to ease. Increasing numbers of newly trained doctors are happier to become salaried GPs working for others, instead of running what is in effect a small business – a situation which has in many cases led to the closure of practices when partners retire.

The past decade has seen the number of salaried GPs in England rise by 65 per cent, while the figures for independent GP contractors fell almost 30 per cent – and around 800 practices pulled down the shutters, with rural areas particularly badly affected.

More worryingly, the overall size of the GP workforce has fallen more than 5 per cent since 2015, but patient numbers have risen. As a result, the number of patients per GP has increased by more than 10 per cent in the past half-decade, a particular problem in more deprived areas that are underserved by primary care.

A chance to end healthcare deprivation

Last month also saw the publication of a Health Foundation analysis of government policies designed to improve general practice in deprived areas over the past 30 years. The thinktank took as its starting point the 'inverse care law', first defined by GP Julian Tudor Hart 50 years ago.

This law describes how people who most need healthcare are the least likely to receive it, and the Health Foundation concluded that the law persists in the NHS today, as GP practices in more deprived areas of England remain relatively underfunded, underdoctored, and perform less well on a range of quality indicators compared with practices in wealthier areas.

The Health Foundation's analysis notes how tackling the inverse care law should align well with the current government's 'levelling up' agenda, but highlights how efforts to tackle it under the Tories since 2010 have been more limited than the efforts of the previous Labour administration.

Similarly, its research on GP numbers from 2015 to 2020 suggests that inequities in their distribution have grown while the Tories have remained in power.

Tellingly, among the lessons drawn from its analysis, the Health Foundation makes no mention of vertical integration, or of GPs being directly employed by hospital trusts to help 'level up', but chooses instead to lead on the core issue of inadequate funding – an issue that isn't mentioned in the Times report.

But if the vertical integration overhaul ever gets off the ground, will GPs actually welcome the opportunity to become NHS employees? The question certainly isn't a new one – the online publication BMJ ran a 'head to head' debate on the subject six years ago, and the growing number of salaried GPs suggests the idea of being 'independent' isn't that important to many medics. The BMA has, nevertheless, labelled Javid's proposals "a kick in the teeth".

Has vertical integration worked in the past?

And would the health secretary's restructure actually work? The past five years has seen several hospitals – including the Royal Wolverhampton NHS Trust and Sandwell and West Birmingham Hospitals NHS Trust – taking over and apparently successfully running GP practices, and a study by the National Institute for Health Research in December 2020 found that these takeovers enabled practices at risk of closure to stay open, and that unplanned hospital admissions were sometimes reduced.

However, the study went on to advise that vertical integration was possibly only "a valuable option to consider when GP practices look likely to fail", and should not therefore be imposed more widely in the primary care sector.

That qualified assessment may not be the best endorsement of vertical integration of primary and secondary care, but there may be other factors at play influencing the health secretary.

In 2020 the Royal Wolverhampton NHS Trust linked up with Babylon Health – famously popular with Javid's predecessor Matt Hancock – to use the telehealth provider's covid app and AI digital care assistant to help patients consult their GP. And then last August it followed that up with a five-year deal to make the Babylon 360 "digital-first healthcare experience" available to 55,000 patients across its nine GP practices operating in the city.

Scaling up the vertical integration already present in Wolverhampton across the rest of England – as Javid seems to be suggesting – may or may not benefit patients in the more deprived areas of the country. But such a move undoubtedly risks scaling up the role of commercial operators like Babylon in our public health service.

There is also the concern – as noted by one GP – that once practices are under the control of hospital trusts, private health providers offering both hospital and community care would eventually step in. The activities of US giant Centene, whose recent purchase of GP surgeries owned by AT Medics is currently the subject of a judicial review in the High Court, hints at how this might play out in the UK..

Martin Shelley

Are GPs already privatised, or still part of the NHS?

Most GPs think of themselves as being part of the NHS, but officially they are classed as independent contractors. It is a status that dates back to the beginning of the NHS, and at the time suited both policy makers – who wanted to keep costs down, and GPs – who were and remain keen to maintain their independence from NHS management. Why does it matter?.

Some commentators now use the status of the 36,000 GPs in the NHS to suggest that it nullifies concerns about creeping private sector involvement because general practitioners are effectively private contractors and have always been part of the makeup of the NHS, but missing from this analysis is an appreciation of motivation. Most GPs treat only NHS patients, work to NHS guidelines and uphold the principles of the NHS. They are not seeking a business advantage or profiteering.

Commercialisation has however crept in through policy changes to the GP contract and controversy has followed through a stream of instances where outsourcing to GP firms has affected standards, fairness and the reliability of services. The catalyst came in 2004 when a new form of GP contract allowed companies to bid for and run NHS GP services. The new APMS (alternative Medical Provider services) arrangement resulted in a number of companies buying up chains of GP practices, but as yet none has become dominant, or expanded significantly and several firms have since left the market including the largest player Virgin – who bought out Assura in 2012, and at that point 358 surgeries were listed as being part of these provider companies.

These commercially orientated APMS contracts currently only account for 3% of the overall number, although as the Lowdown revealed in February 2021 the sale of AT Medics that ran 37 GP practices across London to Operose, a subsidiary of the US health giant Centene, has introduced a huge new corporate player into the market and the suggested possibility of expansion and merger with other services.

Campaigners have reacted to the threat by organising a legal challenge in the High Court. Anjna Khurana an NHS patient and Islington councillor has agued through her legal representatives that there should be a Judicial Review of the sale as she was one of 375,000 patients across London who were not consulted about the takeover.

KEY FACTS:

– 27% of GPs are salaried employees of their practice
– There are 36,000 full-time equivalent GPs (including trainees and locums)
– The average number of patients per practice rose from 7,100 to 8,900 between 2014/15 and 2020/21 – the number of practices fell from 8,000 to 6,800.
– 3% of contracts are APMS (typically used to contract with companies)
– A GP working in a practice serving the most deprived patients in 2019 was, on average, responsible for almost 10% more patients than a GP in the most affluent areas
– General practice in England is under major strain. GP consultation numbers are now higher than before the pandemic but the number of permanent, fully qualified GPs has fallen since 2015. Current policies on general practice risk widening existing inequities

Source: The Health Foundation

NHS reorganisation proceeds before health Bill has been passed

The government's Health and Care Bill has run in to more stormy waters as it continues its committee stage in the House of Lords. Critical voices have been raised about the way so-called 'integrated care systems" (ICSs) are being established on the ground, and the extent to which these are pre-empting the parliamentary debate.

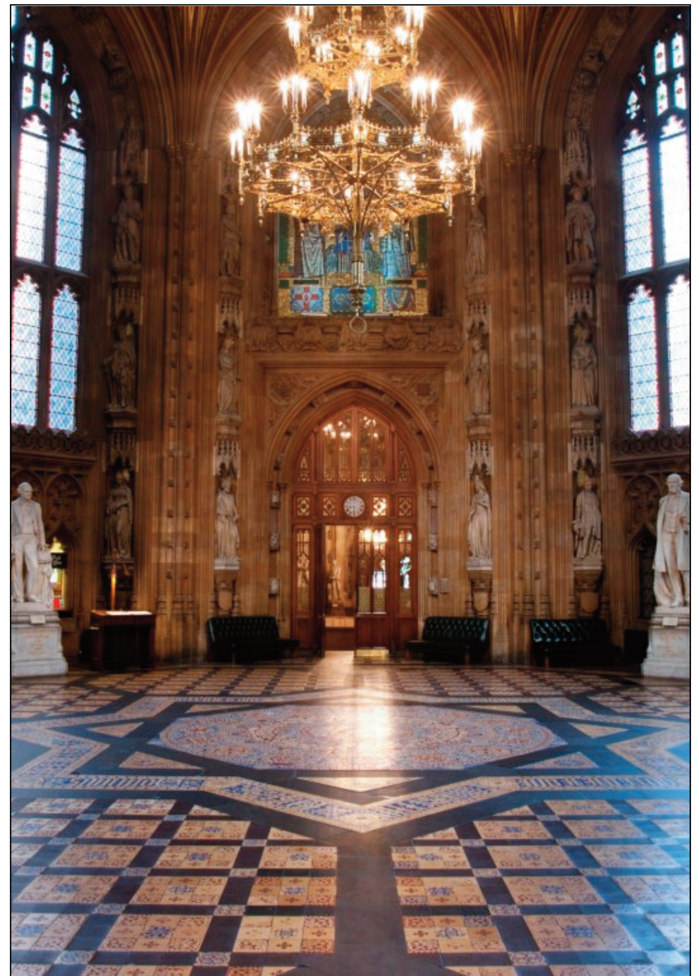
One main focus of criticism of the way the machinery of local integrated care boards is already being put in place, five months ahead of the postponed implementation date, has been the guidelines issued by NHS England that have been used in some areas to exclude elected councillors from representing local government on Integrated Care Boards (ICBs).

The insistence that only unelected council officials should be the voice of their authorities has been forcibly challenged from various benches, not least Lord Scriven from the Liberal Democrats, who complained:

"We are living in a parallel universe. We are discussing the legislative framework for this new system while, out in the real world, the foundations and the bricks are being built.

"People are in place. Dates are being set. People are being told that they cannot be on boards. This Parliament has not decided. Under what legislative framework are these organisations working?

"They have no legitimate powers or approval from Parliament, yet they are being set up. People are being put in place. Chairs are being appointed. Councillors are being told that they cannot sit on ICBs."



The strong protest at the way this was being done forced Lord Kamall from the government to promise to "go back and have a stronger conversation with, in effect, my boss" as well as NHS England, whose guidance on the constitution and composition of ICBs, he insisted, was not statutory.

However some of the amendments proposed could have the effect of forcing NHS England and local ICSs to reopen the appointments process which they began prior to any parliamentary approval of the legislation.

Meanwhile the hugely uneven way in which ICSs have been constituted and begun to function in advance of statutory powers, which we have highlighted in The Lowdown, is underlined again by an HSJ analysis that shows just half of the 42 ICSs published board papers in 2021, and 16 ICSs have never published any papers to indicate what they have been planning or discussing.

And in Norfolk and Waveney ICS, the chair of one of the acute trusts has broken the usual polite silence by declaring that the proposed structure of the ICS, involving no less than twelve separate bodies, is "absolutely daft," and she was "struggling to navigate what each group does".

A look at the document from the "interim partnership board" confirms her view, explaining the complex network of bodies beneath the ICB:

"We are creating five local health and care alliances ('Alliances') based on our current health localities. … They will be accountable to our Integrated Care Board ('ICB').

"We are also creating 7 local health and wellbeing partnerships ('Partnerships') alongside our Integrated Care Partnership ('ICP') to progress our work on addressing the wider determinants of health, improving upstream prevention of avoidable crises, reducing health inequalities, and aligning NHS and local government services and commissioning. These partnerships will be based on district footprints."

Stampede of bids for new hospital funding

In the last issue of The Lowdown (January 19) we reported another instalment of the saga of the collapse of Boris Johnson's promise to build 40 new hospitals by 2030, warning that only one of the six 'pathfinder' projects initially allocated funding now stands any chance of being built by 2025.

All of them are likely to see their initial plans hacked back to fit a new a maximum target cost of £400m, having been asked by the New Hospitals Programme last summer to resubmit their full plans and the cheaper option.

This questions the clinical viability of some of the projects, but corresponds with the limited capital available: as yet only £2.7bn has been allocated to building new hospitals – equivalent to just £450m each for the first six.

The delays and confusion surrounding the initial "fake 40" new hospital projects and the promised upgrade of another 70 hospitals has brought a decline in the construction sector, with a 47% drop in the number of healthcare projects beginning on site in the last quarter of 2021 compared with 2020. Building Better Healthcare reports that "no major projects reached the contract awarded stage" in the final quarter, and "Hospitals, in particular, experienced their weakest period, with the value of work starting onsite in the last quarter of the year falling 62% against the previous year.

But the confusion and certainty of widespread disappointment will have now grown even further with the revelation in the HSJ that a staggering 128 trusts – almost two thirds of all trusts in England – have submitted bids to be one of just eight additional promised projects, to bring the total of new hospitals to 48.

Unless ministers are forced to see sense and review Rishi Sunak's inadequate Spending Review, well over nine out of ten of these trusts will inevitably see their hopes dashed and bids re-

jected – with dozens of projects ahead of them in the queue for a slice of as yet non-existent funding, and no foreseeable prospect of another funding round this decade.

Interestingly Michael Gove's "Levelling Up White Paper," which announces no new money and appears entirely designed to prop up Boris Johnson among his dimmer "red wall" back benchers, retreats from the promise of 48 new builds and offers only a "commitment" to build 40 new hospitals by 2030, with an even more wishy washy "ambition" to deliver 50,000 more nurses.

The Lowdown has consistently highlighted the urgent need for new hospitals to replace those built in the 1970s with defective structural planks, most of which have not been prioritised, and none allocated any capital as yet by the New Hospitals Programme.

Several of these are now either included in larger schemes or submitted separately among the bids that have flooded in as trusts recognise the danger of missing the boat on funding.

Last month one of these, Frimley Health Foundation Trust in Surrey has thrown its hat into the ring, setting out plans for a complete £1.26bn rebuild to transform it into a state-of-the-art net-zero hospital, with more operating theatres and more specialist services, in what a trust spokesperson – clearly unaware of the limited cash likely to be on offer – optimistically described as a "once-in-a-lifetime opportunity."

Another, the collapsing Airedale Hospital in Steeton, is included in the literally fantastic plan from the 'Act as One' health and care partnership that covers Bradford District and Craven – for THREE new hospitals, costing £1.7 bn. Queen Elizabeth Hospital in Kings Lynn has mounted a campaign for the £679m it needs to rebuild the hospital that is being held up by over 200 metal props, warning that it would cost over £550m just to keep adding props.

And Leighton Hospital in Crewe, run by Mid Cheshire Hospitals Foundation Trust – and also in danger of falling down as another victim of defective concrete planks – has also submitted a £663m plan to replace it

Grandiose plans not linked to collapsing buildings include the trusts in Lincolnshire integrated care system, which the HSJ reports have together submitted bids with a total value of £1.2bn.

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"Interestingly Michael Gove's 'Levelling Up White Paper', which announces no new money and appears entirely designed to prop up Boris Johnson among his dimmer 'red wall' back benchers, retreats from the promise of 48 new builds and offers only a 'commitment' to build 40 new hospitals by 2030, with an even more wishy washy 'ambition' to deliver 50,000 more nurses."

In London, Imperial College Healthcare has optimistically submitted its Strategic Outline Case for rebuilding St Mary's Hospital in Paddington, including 840 and "new, user-centred clinical facilities across three main hospital buildings," and a clinical life sciences cluster on the land freed up, at an estimated "£1.2-1.7 billion net, once receipts from the sale of surplus land are taken into account."

Some smaller plans are still coming in above £400m, including the £500m plan to replace Stockport's Stepping Hill Hospital, which has a £95m backlog maintenance bill; Kettering hospital chiefs have boldly submitted the case for investment of "up to £765m" – to fund "the first three phases" of a £1bn-plus 5-phase scheme. Bolton Foundation Trust seems to be a rare bargain bucket exception, having submitted a modest plan for a £252m first phase rebuild of Bolton General Hospital, citing high and significant risk backlog maintenance bills of £165m.

With backlog maintenance bills soaring above £9bn and rising, causing increased numbers of incidents that disrupt patient care, the 128 desperate trust bosses all have a valid case for investment to upgrade, modernise and make buildings safe – but without a sea-change in government policy, at least 120 of them stand no chance of getting the capital they need.

They, along with NHS Providers and the NHS Confederation would be well advised to lend tacit or more open support to the SOSNHS campaign, now backed by over 40 trade unions and campaigning bodies and centred on the need for an emergency down-payment of £20bn to kick-start the refurbishment and expansion of the NHS to meet the needs of patients in this decade rather than later.

John Lister

Billions lost in PPE chaos, fraud and bungled loans

While the NHS has to badger and campaign to secure even a £20bn down payment on the costs of reconstruction after more than a decade of decline and falling real terms funding, evidence keeps emerging of the cavalier way in which ministers have squandered huge sums, especially during the Covid pandemic.

The Department of Health's own Annual Report and Accounts for 2020-21 include a report of the Comptroller and Auditor General to the House of Commons which sets out a tale of incompetence and neglect in the handling of £12.1 billion worth of contracts for PPE that led to an estimated loss in value of £8.7 billion – 72% of the total spend. This includes:

– *"£0.67 billion of PPE which cannot be used, for instance because it is defective"*

– *"£2.6 billion of PPE which is not suitable for use within the health and social care sector but which the Department considers might be suitable for other uses (although these potential other uses are as yet uncertain)"*

– *"£0.75 billion of PPE which is in excess of the amount that will ultimately be needed"*

– *"£4.7 billion of adjustment to the year-end valuation of PPE due to the market price of equivalent PPE at the year-end being lower than the original purchase price"*

One reason the government wound up paying such inflated prices was that ministers had ignored warnings back in 2016 from Exercise Cygnus that there were not adequate stocks of PPE to deal with a pandemic, did nothing, and wound up paying through the nose at the last minute.

The report goes on: "The Department was not able to manage adequately some of the elevated risks, resulting in significant losses for the taxpayer. Nearly two years later, it has not fully restored effective control over some of the inventory purchased: "… The Department's inventory management systems were unable to cope with the significant, rapid increase in procurement and the Department did not maintain adequate records of the location or condition of £3.6 billion of inventory

balances recorded in the accounts at the 31 March 2021…

"The level of fraud risk has increased as a result of COVID-19 – related procurement. A significant increase in new suppliers, a lack of timely checks on the quality of goods received and poor inventory management all contributed to this heightened risk. In these circumstances and given the lack of physical checks on the inventory held by the Department, I have not been able to obtain assurance that there has not been a material level of losses due to fraud."

Storing up problems

To make matters worse much of the excess PPE that has been bought is now being expensively stored: "The Department's records show that as at 31 March 2021, it held 7.5 billion items in 16,000 containers at UK ports plus a further 1.6 billion of items in storage in China; however, because it did not complete its year end stock counts it is unable to confirm this."

The use of so many containers mean that the PPE is not accessible … and "will deteriorate if kept in poor storage conditions," but also mean the Department is shelling out £500,000 per day – £180 million per year – to rent the containers.

£180m would be enough to pay 55,000 nurses.

However even these amounts are dwarfed by the profligacy of the 'Bounce Back Loan Scheme,' which was devised by the same Rishi Sunak who is now refusing any serious increase in NHS spending or investment, and handed out a million loans totalling £47 billion of taxpayers' money – almost equivalent to the defence budget – without even the most minimal checks.

In December the National Audit Office reported the DHSC's estimate that £4.9bn (11%) of these loans were fraudulent, although the figures "excluded some types of fraud:" strangely this was reported as good news after earlier warnings in October that up to 60% of loans – up to £27bn – might not be recovered.

The NAO also argued there was a possibility that some fraudulent loans could be recovered. However the DHSC has also estimated 37% of the Bounce Back loans (£17bn) would not be repaid: and as if accepting this, they have set a pathetic target for the National Investigation Service to recover just £6 million over three years.

The banks handing out the money now face no risk, and so have no financial motivation as lenders to pursue fraudsters. The loans were 100% guaranteed by the government, and they were urged to act with minimal checks or delays. Measures to prevent duplicate applications were not put in place until after 61% of loans had gone out.

So disastrous has been the administration of this scheme – which pushed cash into the hands of companies that had ceased trading, over 1,000 companies that were not even trading prior to the pandemic, and forked out to criminal gangs, and spivs – that Treasury minister Lord Agnew was driven to an angry resignation, walking out of the Lords last month in a vain attempt to draw attention to it in the midst of the 'partygate' furore.

Agnew pointed out the "woeful" failures in administering the Bounce Back Loans, but also warned:

"Fraud in government is rampant. Public estimates sit at just under £30bn a year. There is a complete lack of focus on the cost to society, or indeed the taxpayer."

He pinned blame not least on the Treasury, whose officials "appear to have no knowledge or little interest in the consequences of fraud to our economy or our society."

So it seems certain that upwards of £10bn has been wasted in this way by the same Treasury that is so reluctant to invest in repairing, reopening and rebuilding hospitals and expanding the NHS workforce to meet the needs of a growing population. The Bounce Back Loans and the waste and dodgy deals on PPE almost certainly add up to the £20bn investment demanded by the SOSNHS campaign – before we even start on the huge amounts squandered on test and trace.

But the Department of Health and Social Care is also responsible for wasting valuable funding that should be invested in NHS staff and facilities.

The waste never stops

Even when it's already clear that billions were wasted on paying private hospitals for potential use of their beds in 2020 and 2021, Sajid Javid instructed NHS England to sign a similarly wasteful and pointless contract with private hospitals for the first three months of this year, meaning the private sector will receive at least £225m up to March 31, simply for putting elective capacity on 'standby': if they treat any NHS patients, they will make even more.

NHS England CEO Amanda Pritchard has now been the 'fall guy' rebuked for her handling of the matter by the Commons Public Accounts Committee chair Meg Hillier, and asked to state clearly whether or not the deal represents value for money and the best and only viable option.

Meanwhile Private Eye has highlighted figures from Circle, now Britain's largest hospital chain, and owned by US corporation Centene, showing that despite losing most of its private customer base, the company increased its profitability in 2020, pocketing £113m, thanks to payments of more than £340m from the NHS.

If money can be raised to waste, it can – and should – be raised to invest in expanding and reopening NHS hospitals rather than handed out in dubious deals to private providers.

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Low NHS capacity in mental health leaves it beholden to private companies

The evidence of a massive increase in people in need of help from mental health services in the UK is now incontrovertible. NHS England reports 1.4 million people on the waiting list for care, with an additional eight million who would benefit from care, but who do not meet current criteria.

Funding?

Despite all the evidence in view, mental health services have received a small proportion of the extra funding from the government, with the vast majority of the extra funding going to tackling waiting lists for elective surgery.

What money mental health services have received has gone to community services, such as helplines, and mental health support teams in school. Some money has gone into acute inpatient services, but to convert dormitory accommodation to single rooms, which although much needed should really have been carried out years ago and does nothing to increase capacity.

Capacity?

In short, despite being under intense pressure for beds (see the Lowdown article: Mental health: data backs up concerns over services), NHS mental health services capacity has remained relatively unchanged over the past two years; as a result the massive increase in need can not be met by the NHS.

As a part of a policy to move mental health services into the community, NHS mental health bed numbers have fallen from 23,208 in September 2011 to 18,179 in September 2019 before the pandemic began. Over the pandemic, capacity has changed little and stood at 18,493 in September 2021.

Privatisation

This reduction in NHS capacity over the past decade, despite an increase in need, meant that the NHS had already been forced to turn to the private sector even before the pandemic began. In 2020 the private sector had just over 9,000 beds, the majority of which are used by the NHS, under contract. The in-

come of one of the leading companies in the sector, Cygnet Healthcare, is entirely from NHS contracts and most companies in the sector gain the majority of their income from the NHS.

Private sector cuts beds

Now with the massive increase in need for mental health services and the lack of any investment in increasing NHS capacity, the NHS has become even more reliant on the private sector. However, companies are facing difficulties in recruiting qualified staff, at the same time they have reduced bed numbers – limiting the risk of issues with the standard of patient care and negative reports from the Care Quality Commission (CQC).

A report in the FT notes that despite a sharp increase in need, the private sector is cutting beds for children, with it notes about 325 beds removed in the past five years, which leaves just 1,321 beds for children and teenagers in England.

The Priory, the UK's largest private mental healthcare provider, told the FT that the closures of beds were "the result of having to address a sector-wide shortage of specialist child and adolescent clinical staff" and reducing beds enabled the company to maintain standards and deliver the care expected by the CQC.

The past two years have seen a number of hospitals run by private companies castigated by the CQC, particularly in the area of CAMHS. The two leading companies, The Priory and Cygnet Healthcare, have both had to close wards as a result of damning CQC reports and St Andrews Healthcare the leading not-for-profit in the sector has had severe limitations put on its services due to CQC reports.

A major issue is the difficulty in getting appropriate staff – the CQC reports have often focused on staffing issues and many incidents have hit the headlines of terrible staff behaviour.

St Andrews Healthcare, the leading not-for-profit, in the sector has significantly scaled back its CAMHS services and announced plans to sell its Mansfield site to Nottinghamshire Healthcare NHS Foundation Trust.

The issue of staffing is not restricted to CAMHS wards, CQC visits to St Andrews Healthcare's hospital in Northampton last year led to it being prevented from admitting new patients to some wards without prior consent from the CQC. Short-staffing was a major issue plus not all staff were suitably qualified or competent for their roles. St Andrews was told that it must ensure adequate staffing levels and provide staff with appropriate training for their roles.

Shrewsbury Court Independent Hospital in Surrey run by the Whitepost Health Care Group, closed in December after the CQC imposed urgent conditions requiring rapid improvements at the site. It provided long stay and rehabilitation services for people with mental health conditions, plus a learning disability and autism service. The Whitepost Health Care Group, took the decision to close the hospital due to "a combination of ever-increasing pressures within our sector, operational demands, the age of the building, and challenges with recruitment."

There is some logic in cutting bed numbers, so that the staff the companies do have are sufficient for the number of beds and the short-staffing issue is solved, but with the NHS so reliant on the private sector, there are concerns that any reduction in beds will mean the private providers will charge the NHS higher fees for care, which costs between £500 and £1,300 a bed a day.

Travelling further for care

The government has already missed targets for reducing the number of OoAPs and a reduction in bed numbers in the private sector will make any reduction harder still. With OoAPs there are concerns about the quality of care provided; the disruption to individuals and their families; and the high cost of such care. Lack of investment in NHS beds has also led to the treatment of some patient groups being almost entirely reliant on private companies, with a high number of OoAPs.

A recent report from the British and Irish Group for the Study of Personality Disorder found that due to lack of investment in NHS capacity care for patients with personality disorders appears to have been fully privatised and this has a negative effect on patient care.

The report is the first to look specifically at the use of OoAPs for people with a personality disorder diagnosis and although hampered by a lack of information forthcoming from CCGs, Keir Harding one of the reports authors writing in the HSJ noted that:

"The report found that OoAPs were provided almost exclusively in the private sector. With less than 50 beds for this client group in the NHS, it can be argued that with no consultation or planning whatsoever, we have privatised inpatient care for those who have lived through trauma"

The report also noted that these privately-run units can call themselves a "Specialist Personality Disorder unit" often have nothing to back up these claims and they can not be rated easily as there are no set criteria. Harding noted that "the testimonies of people who have been in such units in the report describe conditions akin to Winterbourne."

The report also found that the market for such units is dominated by the two leading private companies, The Priory and Cygnet Healthcare. With the places so sought after and no additional capacity being opened by the NHS, this group of patients is unlikely to receive the care they need and deserve.

Pandemic of privatisation

The last two years have brought not only a pandemic of Covid-19 and its variants, but also a pandemic of privatisation in England's NHS, according to the most recent Annual Report from the Department of Health and Social Care..

It shows (page 310) a massive 26.6% increase in NHS spending on "independent sector providers", an even bigger 44.5% increase in spending on (mostly privately provided) services run via local authorities, and a much smaller (9.4%) increase in spending on voluntary sector/non-profit providers.

Total NHS commissioner spending on non-NHS providers jumped 27.4% from £14.4 billion in 2019-20 to £18.4bn in 2020-21.

However overall NHS and DHSC spending also increased sharply (up 34.3% from £134bn to £180bn) – so the share of spending on for-profit private providers actually fell, from 7.2% to 6.7%: and spending on non-NHS providers also fell for the same reason from 10.7% to 10.2%.

The inflated level of spending on private provision, which rose dramatically with the £2bn spent on block-booking private hospital beds to treat NHS patients in 2020, is likely to remain high for at least the next three years as NHS England's £10bn 4-year framework contract with private hospitals works through, along with increased use of contractors.

But of course once the framework contract runs out the NHS will still not have been able to invest the necessary funds to re-open NHS capacity that was closed in 2020 to cope with Covid – so the probability is more years of inflated spending that is hugely profitable to private providers, but disruptive, inefficient and short sighted use of resources by the NHS.

Hence the SOSNHS call for an immediate increase of £20 billion in capital and revenue to kick start the repair, renewal and reopening of NHS beds and expansion of staff.

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