The lowdown

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

Now NHS faces £20bn-plus budget gap

The Lowdown is running out of vocabulary to sum up the situation confronting the NHS, as each revelation on the financial front reveals a further deterioration.

A month ago we headlined 'Worst-ever crisis set to get worse': but the verbal and written report to last week's NHS England Board meeting has shown things have slid even further downhill.

NHSE's chief financial officer Julian Kelly told the Board the NHS plan faces a funding gap of over £14 billion by 2025: he warned that this raises real questions now over whether commitments on cancer, mental health and more are affordable. But even that understates the scale and immediacy of the problem. His report's executive summary shows that the gap is even bigger, and still growing:

continued on page 2...

Also in this issue...

...continued from page 1

"In total we have committed to delivering £12bn of annualised savings by 2024/25 including reducing exceptional funding for covid. The impact of higher inflation this year and the potential recurrent effect of this year's pay settlement and other responsibilities transferred to us could add substantially to this. In addition to this we could face a further £6-7bn depending on how inflation feeds through into pay and other prices next year."

So the gap to be bridged by "annualised savings" (aka cutbacks) by 2025 is likely be upwards of £18-£19bn. The board paper admits all of NHS England's initial plans were based on three false assumptions:

– typical levels of inflation of around 2% per year
– covid demand and extra costs would reduce significantly
– no significant reduction in capacity of the social care system

Instead the situation is very different: CPI inflation is currently at 9.9%, and expected to rise further before (hopefully) eventually falling back

Covid-19 remains "a significant draw on NHS resources" – with MORE beds occupied by Covid patients this year than during 2020 or 2021: "on average in 2022 so far 9,743 beds have been occupied each day by Covid-19 patients compared to 7,691 in 2021 and 7,313 in 2020."

"The domiciliary care workforce [55% of whom are on zero hours contracts] has reduced over the past year and as a result the ability to discharge to people's homes is highly challenged."

The latter point helps explain why "The number of patients in hospital for more than a week is around 7,000 higher than it was before the pandemic, largely because of difficulties in discharging patients from hospital."

Inflation a major factor

The combination of an average 12,000 patients per day in hospital who should have been discharged to social care and 9,700 beds occupied by Covid patients means over 20% of NHS acute beds in England are tied up and unavailable for emergency patients or for those needing elective operations.

Inflation is increasing the cost of non-pay goods and services, but also adding to the pressure to increase beyond the hopelessly inadequate £1,400 flat rate NHS pay award – which was in any case not fully funded. Even while health unions are balloting for strike action seeking a much bigger increase for this year, NHSE is looking ahead to future implications:

"If headline pay awards in 2023/24 were to track this year in response to higher inflation and similar to private sector earnings, and non-pay non-drugs inflation is at 9%, then the further cost increase next year (above the level assumed in current financial plans and above the recurrent impact of 2022/23's additional costs) could be up to c£6-7bn."

However the Treasury has insisted that despite surging inflation there will be no revision of last autumn's spending review, which assumed pay rises of no more than two per cent over the next three years.

Savings strategy unlikely to help

And while NHSE is adding up the scale of the likely shortfall, Integrated Care Boards are being told to plan to generate savings which fall way short of the likely total. NHSE's board paper confirms warnings in July from the Nuffield Trust's Sally Gainsbury that this year's NHSE budget "was planned to be 1.4% smaller in real terms in 2022/23 than it was in 2021/22," and already required a "total efficiency from NHS systems" of around 5% (£5.6bn).

On top of this the latest plans seek further "savings" of just £6.4bn in the next two years, equivalent to 2.9% of budget (£3.6bn) in 2023/24 and 2.2% (£2.8bn) in 2024/25.

So even if all of the literally incredible targets for savings are achieved, they would add up to just £12 billion – only two thirds of the likely total gap, which could yet grow wider. But the chances of generating even this much are slim to non-existent.

As NHS England points out in the same Board paper: "These [2023-2025] annual efficiency requirements – agreed by the NHS … are higher than the NHS has historically delivered (c1%/year)."

Sally Gainsbury has explained the recent history of under-funding of the NHS coupled with unrealistic and inflated assumptions of what "savings" could be generated – effectively rolling along a deficit that has now grown to £8bn.

The Lowdown has warned that the 42 new Integrated Care Boards were set up in July with huge underlying deficits, and few if any plans to generate savings on anything like the scale that would be required.

Nevertheless all but five of them somehow managed to cobble together plans that appeared to promise to achieve break-even, and NHS England nodded them through. But now with winter coming and a tight schedule to identify and make any savings, two thirds of ICBs are already lagging behind on their plans.

Earlier this month HSJ also reported that only 7 of the 42 ICBs have delivered targets for improving mental health

services set out in the 2019 Long Term Plan. This comes as the Royal College of Emergency Medicine highlights the problem of delays in treating mental health patients who seek help via A&E, with half of Emergency Departments in England reporting waits of 12 to 24 hours for a child or young person to see a specialist mental health professional, despite the accepted standard for adults being a one hour wait to be seen.

The Royal College of Psychiatrists now says its research found 43% of adults with mental illness saying long waits for treatment have led to their mental health getting worse. Almost a quarter (23%) have to wait more than 12 weeks to start treatment, with many so desperate they turn to A&E or dial 999.

Meanwhile Shaun Lintern in the Sunday Times has revealed that NHS England has identified 10 areas including big city regions like Birmingham and Leicester, "which it fears could see a 'system failure' this winter when 999, A&E, hospitals and social care all collapse."

The first few days of autumn have already seen trusts around the country declaring critical incidents or cancelled operations due to overwhelming demand and struggles with discharging patients.

All this comes before we hear whether or not Liz Truss's government intends to implement her suggestion/threat to slash £10bn per year from funding allocated to the NHS from the 'health and care levy,' and hand it to social care.

Last month Sir Charlie Bean, a former deputy governor of the Bank of England argued public spending would have to be cut back so hard in the wake of the 'mini-Budget' that it could threaten the existence of the NHS as a free service.

HSJ reports NHSE chair Richard Meddings warning the Board meeting that the savings required could add up to 10 per cent of the NHS's cost base, which would mean "making presentations to the government about various options for their consideration".

John Lister

New dangers to NHS from think tank critics

The Truss government has set out its stall and political scientists have confirmed what is plain to see – that it is lurching further to the right. You might wonder then where are all these more extreme ideas coming from?

The Guardian's George Monbiot has highlighted the role of right wing lobby groups, noting that Truss's senior special advisor is Ruth Porter, formerly communications director for the opaquely-funded Institute for Economic Affairs (IEA). She has called for charging patients to use the NHS. Porter has also been head of economic and social policy at another opaquely funded far right body, Policy Exchange, and it was Porter who established a web page for the "Free Enterprise Group" of Tory MPs which was apparently set up by Truss in 2011.

Truss's chief economic advisor is Matthew Sinclair, formerly chief executive of the so-called Taxpayers Alliance, which is obscurely funded by foreign donors with little evidence that it involves any UK taxpayers.

Truss's interim press secretary has also worked as research director for the Taxpayers Alliance. Her health advisor was senior researcher at the Centre for Policy Studies, which claims to be Britain's "leading centre-right think tank" and was set up by Margaret Thatcher and Sir Keith Joseph in 1974. It has also argued for fees to be levied to visit a GP or for hospital treatment.

Truss's political secretary was head of government affairs at the neoliberal Adam Smith Institute, which in 1984 attempted to push Thatcher further to the right by publishing the Omega Report – a manifesto for a privatised, insurance-based health system, and has repeatedly argued for a break from the tax-funded NHS model. In 2017 a research paper argued for

"Patient co-payments …to be extended, with care, to reduce marginal and unnecessary demand on NHS services."

Since her conversion from Liberal Democrat to Conservative MP Truss has consistently leaned to the far right of the party and what Monbiot sums up as "dark money think tanks". She has spoken at more meetings of the IEA in the last 12 years than any other politician.

And Monbiot points out that on Twitter the IEA's head of public policy Matthew Lesh was confident enough to agree with the suggestion that Truss's government has now effectively handed power over to the extreme neoliberal "think tanks" that promote the interests of their donors.

All of this is made much easier by the connivance of right wing news editors, especially in the BBC. As Monbiot has argued:

"Major BBC programmes including Today, Question Time, Newsnight and Any Questions? are populated by speakers from the Institute of Economic Affairs, the Adam Smith Institute, the Taxpayers' Alliance, the Centre for Policy Studies and Policy Ex-

change. These groups also happen to have been rated by the campaign Who Funds You? as among the most opaque of all those it investigated."

One of the few broadcasters to have challenged the credentials of the IEA was LBC's James O'Brien, who described it as a "hard-right lobby group for vested interests of big business, fossil fuels, tobacco, junk food." When the IEA complained to Ofcom about this, its complaint was rejected, with Ofcom ruling that he had not distorted the facts.

Created to mislead

Three years ago a long read article in the Guardian explained the origins and the key role of the IEA, which had been formed in Britain back in 1955, in spawning the later proliferation of hard right wing foundations and institutes around the world, and especially those in the USA which are now lavishly funded by reactionary billionaires including the Koch brothers.

From the outset, as Adam Curtis outlines in his piece for the BBC, the IEA was created as a misleading front organisation that aimed to conceal its political message. It would masquerade as a "scholarly institute," recognising that it was "Imperative that we should give no indication in our literature that we are working to educate the Public along certain lines which might be interpreted as having a political bias.

"In other words, if we said openly that we were re-teaching the economics of the free-market, it might enable our enemies to question the charitableness of our motives."

That these organisations and those trained by them now have their hands so close to the levers of government is especially frightening for those who value the NHS, welfare and other public services. We already know these will all be facing real terms or actual spending cuts in the November 23 budget – as a result of the £43bn of tax cuts that have been announced, mainly benefiting the richest five percent.

But with the new power enjoyed by the IEA has come bravado and arrogance, with the mask cast aside. The IEA's Director, Mark Littlewood, talking about Kwarteng's disastrous 'mini-budget' on Sky News admitted: "You're not going to like this package if you care more about the poor".

John Lister

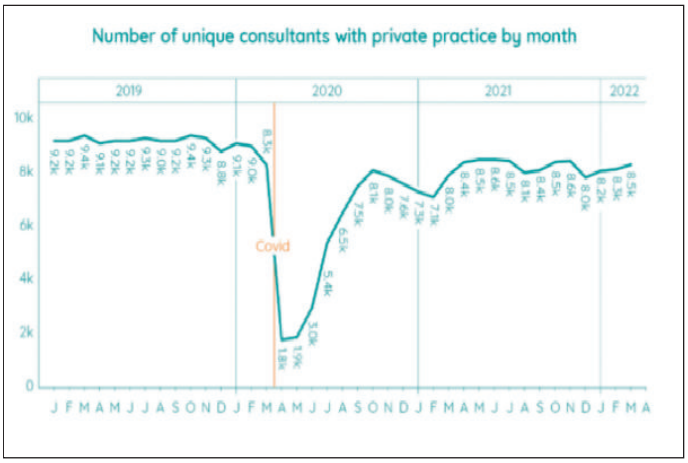
NHS patients are turning to the private sector – or are they?

A stream of recent media stories have pointed to the plight of patients suffering distressing delays in accessing NHS treatment. An increasing number have opted to 'go-private', dipping into savings to access faster treatment – becoming self payers as they are called in the industry. But figures released by the Private Healthcare Information Network shed a different light on this story, suggesting that overall use of private health sector is not expanding in the way that some of the media stories imply.

According to PHIN figures, admissions to independent hospitals over the past three years are only slightly up when comparing figures for the most recent quarter with the equivalent period before the pandemic (198,000 – for quarter 1 of 2019 and 200,000 for Q1 of 2022).

There clearly has been a significant rise in self-pay patients – 39% since before the pandemic, which is the trend picked up in the media, but interestingly these hospitals are treating less patients with private medical insurance, compared to the same period before the pandemic.

PHIN figures also show that the Independent sector has 10% less active consultants working for it than in 2019. This is despite a sharp increase in their private sector activity since the height of



the pandemic when consultants were doing a fraction of their current level of private work.

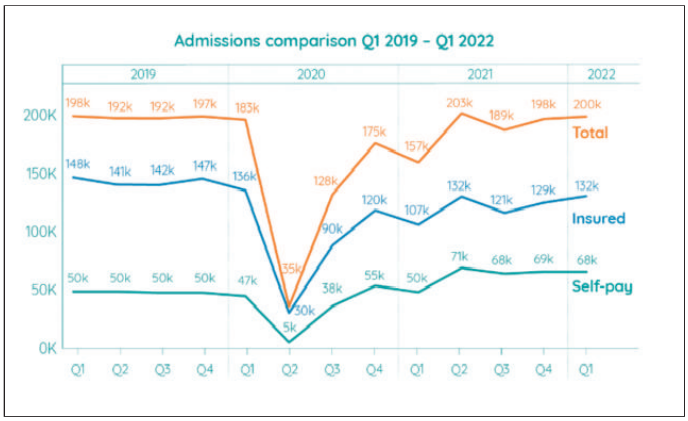
This perhaps mirrors some trends within the NHS where stress and overwork are forcing many to think about quitting or reducing their hours. However it also re-emphasises the reality that most consultants who work in the private sector also work for the NHS.

To substantially increase their work in one sector will frequently mean a decrease in the other. In policy terms this means there is little scope to recruit the private sector in order to lessen the NHS elective waiting lists as, to a large degree, it is very often the same group of surgeons doing the work in both sectors.

Although the rise in self payers is being pronounced as a potential boom period for the independent sector it remains to be seen whether the big players in the sector will actually be able to convert their self pay customers into fully fledged private insurance policyholders.

Despite long periods of underfunding in the NHS and previous eras where long waits are prevalent, the percentage of the population covered by private medical insurance has stubbornly remained flat at around 12%.

With the cost of living crisis biting ever deeper, and more broadly across society the NHS remains the only option for the vast majority of the population to access comprehensive healthcare. Despite policy makers leaning heavily on the independent sector in their plans to reduce NHS waiting lists, the reality is that only a rise in NHS capacity will provide a long term solution.



Volume of consultants by Top 10 speciality

Speciality name	Jan - Mar 2019	Jan - Mar 2022	% difference
General medicine	1,155	705	-39%
Cardiology	1,030	810	-21%
Gastroenterology	1,030	880	-14%
Urology	890	815	-8%
Plastic surgery	810	740	-8%
Gynaecology	1,120	1,030	-8%
Trauma & orthopaedics	2,760	2,545	-8%
Ophthalmology	1,095	1,020	-7%
ENT	720	675	-7%
General surgery	2,340	2,215	-5%

Right wing trying to drag the NHS back to pre-war system

As the Tory conference gathered, one-time Brexit secretary David Davis became the latest mouthpiece for the hoary old argument for scrapping the NHS as a tax-funded system and opting instead for so-called "social insurance".

The predictable platform for this latest outpouring of hackneyed and false assertions was the Daily Telegraph, but similar arguments have been retailed time and again in the last few years in the Times, the Daily Mail, the Spectator, and sadly, taken too seriously by BBC correspondents.

Liz Truss herself is one of an 8-strong Parliamentary Board of the '1828 Committee', whose 'Neoliberal Manifesto', published jointly with the Adam Smith Institute in 2019, condemns the NHS record as "deplorable" and states:

"We believe that the UK should emulate the social health insurance systems as exist in countries such as Switzerland, Belgium, the Netherlands, Germany and Israel, among others. Under these systems, individuals pay regular contributions — as they currently do for the NHS through taxation — to their chosen insurer. They are then free to seek treatment from a medical provider of their choice and their insurance company subsequently reimburses the provider for the expenses incurred."

Of course some of the information used to argue for change is correct, and we can all agree that the NHS – especially after a decade of real terms cuts in funding and the extraordinary problems posed by the pandemic – is far from perfect.

But it's consistently people who supported the decade of de-

clining real terms funding, ignored the growing shortages of NHS and social care staff, and who have endorsed the policies that have undermined public health and widened the gap in healthy life expectancy between the richest and poorest in society, who delightedly point to statistics showing the NHS performing less well on measures such as cancer and heart attack survival than other European health systems.

They are delighted because they feel they can use the NHS's worsening problems to argue for changes that would otherwise be dismissed out of hand, and propose changing to health care systems that offer more openings for the private sector to cash in.

Winding back the clock

Indeed they feel they can exploit widespread ignorance of the systems they are advocating to make ridiculous arguments that the NHS as launched in 1948 is 'out of date', but it should be replaced by a social health insurance system … dating back to 1883. Indeed Davis is trying to make a case for winding back the clock to reinstate the failed system that was in place in Britain before the NHS.

Social health insurance began in Germany as workplace health insurance, covering only the elite workers in the initial schemes, and only while they were working: it did not cover their families, retired workers or of course the millions of people, working or unemployed, who were left outside the scheme. By 1885, just 10% of the German population was insured – by a total of 18,776 sickness funds.

This is similar to the system that prevailed in Britain prior to the establishment of the NHS in 1948, and left more than half the population without adequate access even to primary health care. The German and other social health insurance systems have only developed towards universal health systems as they have been extended to cover the other groups through increased levels of tax funding (i.e. become more like the NHS).

Davis claims "successive Conservative governments have shied away from large-scale reform of this most fundamental public service," – completely disregarding the succession of massive, costly and disruptive "reforms" to the NHS rammed through by Margaret Thatcher in 1989-90, David Cameron's coalition (Lansley reforms) 2010-2013 and the latest ramshackle Health and Care Act pushed through under Johnson and implemented in July.

He argues with no evidence that "The NHS is plagued by ineffective bureaucracy … the ramshackle nature of the organisation is clear for all to see."

But he is apparently blissfully unaware of the much larger and more complex bureaucracy that would be required to run a social insurance system. Germany's health insurance system consists of 110 sickness funds – meaning that health spending also funds an extraordinary and complex bureaucracy.

Davis also ignores the additional fragmentation and complexity that have been the result of decades of outsourcing and privatisation under Tory (and New Labour) governments.

Why social health insurance?

For many years the more savvy advocates of more privatised systems have recognised the folly of suggesting any kind of US-style system based on private insurance – which is notorious for its extravagant waste, inflated costs, and the numbers of people left uninsured or under-insured, facing huge and unpayable bills for health care. Hundreds of thousands of Americans each year are bankrupted by hospital bills.

The favoured models are therefore systems that can be portrayed as relatively close to the NHS – apparently offering universal coverage, free at point of use.

David Davis names no specific model, but a recent article by BBC health correspondent Hugh Pym takes the example of Germany, where the first 'social insurance' system for health care

was set up under authoritarian Chancellor Bismarck in 1883.

Pym quotes Dr Kristian Niemietz, of the Institute of Economic Affairs, who argues it could be a blueprint for reform in the UK, and claims: "Social health insurance systems tend to have better healthcare outcomes."

Of course outcomes are related to inputs, and the figures show Germany spends a lot more than the UK on health – and has done for a very long time. Misleadingly, Pym asserts: "Funding of the two systems is similar. Germany spent just under 13% of its gross domestic product on health in 2021, … The equivalent figure for the UK was around 12%."

There are several problems with this. The first is that German GDP is much (34%) larger than the UK, and Germany spending an additional 1% of GDP means that its total health spending in 2021 was 45% higher than the UK.

The second problem is that the comparison of spending is based on 2021, a year in which health spending – especially in Britain, even though much of it was wasted – was heavily distorted (inflated) by the Covid pandemic.

And the third problem is that what really matters in terms of resources on the ground is not the share of GDP spent on health (which has been recalculated several times since 2009, to include more social care) but the amount spent per head of population. On this measure, UK spending is much lower than many of the countries that appear to be delivering better health outcomes. OECD figures show that Germany for example spent 46% more per head on health than the UK in 2019, and 38% more in 2020 when the NHS budget was apparently inflated by Covid spending.

So it's no real surprise to find that after several decades of much higher spending on health, Germany is much better equipped to deliver good outcomes, as Hugh Pym notes:

"The German system is better staffed and stocked than the UK, relative to the population. Analysis by Nuffield Trust shows in 2019 the UK had around nine nurses per 1,000 people, while in Germany there were about 14. The disparity in bed numbers was wider – with Germany's eight beds per 1,000 patients more than three times higher than the UK figure."

Spending: comparing like with like

It's also important to remember that the overall spending figures include ALL spending, whether by public sector, on private care and out of pocket payments by individuals. Anita Charlesworth of the Health Foundation points out the significant difference if we compare only public spending on health care:

"Using another common measure, public spending on health care was equivalent to 8% of GDP in the UK in 2019. This is more than the OECD (6.4%) and the EU14 (7.2%), but less than the G7 (9.4%). It is notable that the UK spent more as a share of GDP on health care than the EU14, and yet had a lower spend per person. This is explained by the UK's relatively low GDP per person, which in turn illustrates how spending is determined both by the relative priority afforded to health care and by wider economic prosperity."

Other issues are also often glossed over in discussing the German system. Pym notes that "around 86% of the population there are enrolled in schemes run by not-for-profit insurance organisations known as sickness funds."

What he doesn't say is that German self-employed and employees who exceed a certain income threshold may choose to stay with the main system or opt for private health insurance (PHI), which is provided by 41 insurance companies. PHI covers around 10% of the population, including civil servants; the remainder (e.g. military) are covered through special schemes. So the German system is a two-tier health care system, not universal health care.

Another important difference is that social health insurance schemes are largely funded by payroll taxes levied on the employed workforce (and their employers) – so those, including very wealthy people, who live off unearned income (shares, rents, or inherited wealth) or are not on company payrolls make no contribution to the wider pool of health insurance. This is much less equitable than a system funded through general taxation levied on the whole population.

Nor is health care free to access in Germany. It is one of the systems that levies a fee for hospital care: adults have to pay €10-15 per day, up to a maximum of 28 days in a year.

Other social insurance systems

In case anyone thinks we are picking a select example here, or believes other social health insurance schemes are more akin to the NHS, it's worth noting that Switzerland, Belgium, and the Netherlands (the other countries cited as preferable models by the IEA and by Truss and her '1828 committee' colleagues) all spend significantly more per head on health than the UK.

Switzerland is the highest spending country after the US, and spent 58% more per head on health than the UK in 2019 and 43% more in 2020; Belgium spent 22% more than UK in 2019, but bizarrely CUT health spending in 2020, remaining 5% higher; and Netherlands spent 29% more per head in 2019 and 23% more in 2020.

It's also important to note that not only do these countries spend more on healthcare, they also leave patients stuck with more of the cost of that care:

Switzerland is one of the wealthiest countries in Europe, yet the proportion of private 'out of pocket' spending on health is ex-

ceptionally high at 26% of total health spending. This means that low and middle income households pay a higher proportion of their income for health care than the richest. Swiss patients wanting health care have to pay a "deductible" (fixed amount to be paid before insurance cover begins to reimburse costs) as well as a copayment (a percentage of the cost of treatment) which cannot by law be covered by insurance. There is a £12 per day fee for hospital inpatient treatment.

Belgium, with slightly higher population than London, levies higher user charges for mental health and dental care, again limiting accessibility especially for the poorest.

The Netherlands has a complex combination of mandatory and voluntary health insurance in which costs fall disproportionately on poorer people. Even the right wing US Heritage Foundation points out that low and lower-middle income individuals end up paying between 20-25% of their income in healthcare costs: this is far less equitable than the UK system. Competition has increased the bureaucratization of the Dutch healthcare system, with over 1400 different insurance packages, making choice for consumers extremely complicated.

A health service, not insurance

It seems the right wing's ideal models aren't so ideal after all if we look more closely. But David Davis and others also try to reinforce their case with a lie. They insist, against all of the evidence that our own NHS is an insurance system. Davis argues:

"Insurance-based system" is considered a dirty phrase by some. But the truth is that we already use a principle of in^surance to fund our health service: National Insurance."

But the argument for this is flimsy in the extreme: "Indeed, NHS England's budget is of a similar scale to the total National Insurance take. The recent arguments about raising NICs show that people understand healthcare has to be paid for."

This is as downright dishonest as the recent claim by new health Secretary Therese Coffey that the Tories were the Party that conceived the NHS in 1944.

Davis knows full well that only in exceptional circumstances have governments turned to use National Insurance money to fund the NHS, which has always mainly been funded from general taxation – effectively sharing the risk and the costs of ill-health across the whole tax-paying population, the widest possible pool. Liz Truss and co have just reversed the most recent plan to use NI funds for the NHS.

Aneurin Bevan, the Labour minister who pushed through the legislation to establish the NHS in the teeth of opposition from the Tories, who vote 21 times against it, clearly rejected any notion that the NHS was an insurance scheme and any confusion with National Insurance. It seems the right wing 'think tanks' and their allies prefer to recreate the confusion.

But why is David Davis so keen to suggest that the NHS is an insurance scheme? He wants to argue for a greater private sector slice of the action. He says so in so many words: "Involving private firms in the provision of health insurance … would simply mean sharing the burden (and the opportunity) between the state and the private sector."

Of course there is no "sharing" involved, other than allowing the private insurers to carve out a profitable niche for themselves. The private insurance industry has no interest in chipping in to the cost of running the NHS – or indeed in paying out for patient care if they can possibly avoid it, which is why they are so reluctant to insure older people and those with pre-existing conditions who are more likely to be making a claim.

So how would private insurance become an issue under Davis's view of social insurance? Only if it's linked with preferential access to hospitals, mental health and GPs, all of which would presumably be levying fees. So it's no so much changing the mechanism of funding that's at stake, but privatising and commercialising the provision of health care, again to the benefit of the rich, and disadvantage of the poor.

It's clear that once the myths and falsehoods are discarded social health insurance is not the answer to any of the big questions facing the NHS today.

As Roy Lilley recently argued:

– There are huge waiting lists, an exodus of staff, wages are poor, working in health and care is unattractive. Would a social insurance system, fix it? No.

– We don't have enough health professionals nor enough beds. Would a social insurance system fix it? No.

– There are some outcomes that are better elsewhere… but it depends on what comparator you pick. Would a social insurance system fix it? No."

We could add that there are long queues of ambulances outside A&E, long delays in emergency admissions, long delays accessing mental health care.

And social insurance and private provision are absolutely no use in dealing with these problems, either.

In 1948 The NHS moved decisively beyond the social insurance system that had prevailed from 1911, and established a system that was universal and more forward looking, allowing services to be planned on the basis of need, patients to access services regardless of ability to pay, and national training systems to be put in place for doctors and professional staff.

Nobody but the crackpot right wing of the Conservative Party and neoliberal lobby groups now wants the discredited old system back.

John Lister

Revolving door used by former Test and Trace civil servant

A recent report in the HSJ on the move by Hamza Yusuf, a senior civil servant who oversaw the £37bn Test and Trace budget, to the consultancy firm Deloitte, has highlighted once again the involvement of such firms in the NHS.

As a finance director at the Department of Health and Social Care from November 2020 to October 2021, Mr Yusuf had overall responsibility for the £37bn Test & Trace programme budget. More recently he was a strategic finance director at the UK Health Security Agency (UKHSA), which has taken over the test and trace programme.

Mr Yusuf's new employer, Deloitte, has been a major recipient of contracts within the test and trace system. At one point Sky News reported that more than 1,000 consultants from the company were being employed, which in pure headcount terms, was "about the size of a small UK government department."

In May 2021, the FT reported that Deloitte had been awarded 26 contracts as part of the pandemic response worth up to £278.7m, most of which were to support the rollout of the UK's test-and-trace programme.

Despite a damning Public Accounts Committee report in October 2021, which noted that despite having a budget of £37 bn over two years, and a huge spend on management consultants, the test and trace system had failed to achieve its main objective of reducing transmission and aiding a return to normal life, the employment of management consultants continues.

The contracts keep on coming

In December 2021, the FT reported that the UKHSA had signed at least four contracts with consultancies Deloitte and Accenture relating to the delivery of the programme, with the potential to extend until April 2025. Deloitte was awarded a contract worth £900,000 that included the preparation of "evidence" for the Covid public inquiry.

At the time Labour protested that it is "completely wrong for the company to be awarded a contract to mark their own homework."

By June 2022 according to a letter sent to the PAC, by Dame Jenny Harries, head of the UK Health Security Agency (UKHSA), NHS England's Test and Trace system had reduced management consultant numbers, but it was still continuing to employ hundreds.

The UKHSA may be reducing its management consultant headcount, but elsewhere in the NHS and related government departments there are still contracts for them. According to ContractFinder, the government's database of public contract activity, Deloitte was awarded 31 contracts from 1 January 2022 to 1 October 2022 within the area of the NHS or UKHSA.

In February 2022, The Lowdown reported that seven companies – Bramble Hub, Deloitte, EY, KPMG, McKinsey & Co, Newton Europe and PwC – are being paid up to £42m for an initial two-month data contract.

The contracts form part of the then health secretary Sajid Javid's 'delivery plan' to clear the surgery waiting list backlog. The contract is designed to provide "system planning" to support the elective recovery programme.

To help secure the future of our NHS through campaigning journalism, please support us

Dear Reader

Thank you for your support, we really appreciate it at such a difficult time. Before covid-19 the NHS was already under huge pressure, and after it's all over there will be a backlog of patients, queues of people affected by the crisis, and a hugely tired workforce.

From that moment we will need a much more credible plan to fund, support and protect our brilliant NHS. Our goal is to help make this happen and we need your help. We are researchers, journalists and campaigners and we launched The Lowdown to investigate policy decisions, challenge politicians and alert the public to what's happening to their NHS.

It is clear from the failures of recent years that we can't always rely on our leaders to take the right action or to be honest with us, so it is crucial to get to the truth and to get the public involved. If you can, please help us to investigate, publicise and campaign around the crucial issues that will decide the future of our NHS, by making a donation today. Our supporters have already helped us to research and expose:

- unsafe staffing levels across the country, the closure of NHS units and cuts in beds
- shocking disrepair in many hospitals and a social care system that needs urgent action, not yet more delays
- privatisation – we track contracts and collect evidence about failures of private companies running NHS services

First we must escape the covid-19 crisis and help our incredible NHS staff. We are helping by reporting the facts around the lack of protective equipment for hospital staff but also for thousands of carers. We are publishing evidence about more community testing and the shortcomings in our strategy to beat the virus. Even though they have a tough job, there have been crucial failings: on testing, PPE and strategy, and we must hold our politicians to account and challenge them to do better. We rely on your support to carry out our investigations and get to the evidence.

If you can, please make a regular donation, just a few pounds a month will help us keep working on behalf of the public and NHS staff - thank you. We all feel such huge gratitude and respect for the commitment of NHS staff and it's so impressive to see such strong public support. Let's hope that we can give the NHS the thanks it deserves and crucially, secure its future.

With thanks and best wishes from the team at The Lowdown

EVERY DONATION COUNTS!

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.

Supporters can choose how, and how often to receive information, and are welcome to share it far and wide.

Please send your donation by BACS (54006610 / 60-83-01), or by cheque made out to NHS Support Federation and posted to us at Community Base, 113 Queens Road, Brighton BN1 3XG

If you have any other queries, or suggestions for stories we should be covering, please email us at contactus@lowdownnhs.info