The lowdown

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

When 'record' spending is nowhere near enough

There are, according to the famous phrase, "Lies, damn lies and statistics". The Johnson government feeds the public on a constant diet of all three: but perhaps the most confusing lies are those quoting statistics on health spending.

Increases need to be understood in the context of the starting figure, funding needs to be assessed against needs and demands. 'Record' spending can still be inadequate – and in this case has been since 2010. High levels of taxation do not mean taxation is high enough the meet needs, or levied fairly.

How many times in the run-up to the 2019 election did ministers cynically misrepresent the scale of the tight-fisted funding settlement for the NHS that had been agreed by Theresa May's Chancellor Philip Hammond at the end of 2018, quoting "an extra £33.9 billion" over five years in cash terms, rather than its real terms value of just £20bn?

How many times have Tory ministers used crude cash figures to claim "record" spending – when the real terms allocations since 2010 have been amongst the meanest since the NHS was established in 1948?

NHS Providers Chief Executive Chris Hopson calculated back in 2019 that if NHS spending since David Cameron first took office had just kept pace with the previous long term average annual increase, spending on health and social care would have been £35 billion per year higher than it was.

But year after year government and Conservative spin-doctors have successfully fed much of a poorly-informed mainstream news media with the illusion that the NHS has been lavishly funded under Johnson, so few of the assertions are seriously challenged.

The confusion was multiplied in September by the deliberate obfuscation over the Johnson government's decision to push through a £36 billion 3-year package of National Insurance tax increases on the lowest-paid workers, allegedly to spend more on the NHS and social care.

In fact less than half of the £36bn, just £15.6bn over three years, is earmarked for NHS England. Another £6bn goes to the devolved governments (Wales, Scotland and Northern Ireland), £9bn is simply to be handed to the Department of Health & Social Care – and £5.4bn, again over 3 years, is reserved for social care – too little, too late, and without the necessary reforms to a crisis-ridden largely privatised system.

Ridiculous claims have been made over how much this extra money, which does not even begin to trickle through until next year, can achieve – and how much indeed

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is even allocated to England's national health service.

Now these figures have been followed by the confusion of the Spending Review, which runs up to 2024-25. The Treasury's Red Book shows that the new money increases the allocation to the Department of Social Care by an average of 4.1% per year between 2021 and 2025.

This appears to be close to the long run average increases prior to the Tories taking office in 2010. But the next column shows that the average increase from 2019 to 2025 would be much lower – at 3.3%.

Worse, by no means all of the money allocated to the DHSC goes to paying for NHS treatment. NHS England's average increase in funding from 2019-2025 will be just 3.1% – well below the previous long run average.

This inadequate level of increase even to keep pace with cost and demographic pressures comes after the meanest-ever decade, in which government health spending grew in by an average of just 1.3% per year between 2009–10 and 2015–16, leaving it effectively frozen in real terms from 2010-2019.

Even if we accept that the specific added costs to the NHS of the Covid pandemic have been covered by additional allocations, these calculations take no account of the growth – by almost 5 million (7%) – of the UK population over the same period, bringing with it an increase in numbers of older people, whose health care on average is more expensive.

As a result of these factors, the gap between resources and demand for health care had already increased England's NHS waiting list to more than 4 million before the Covid pandemic.

The combination of beds (and staff) tied up treating thousands of Covid patients with the reduction in bed numbers to ensure social distancing has left the NHS even further lacking in capacity to keep up with elective referrals or catch back up on a chronic problem of lengthening waiting times. The waiting list is now edging up towards 6 million, with over 200,000 waiting over a year – and growing numbers waiting over two years.

Capital allocations squeezed for a decade

To make matters worse, NHS capital allocations have also been squeezed to unrealistic low levels for a full decade, leaving trusts lacking the resources required even to keep up with routine maintenance and the replacement of clapped-out equipment. The backlog maintenance bill has rocketed to £9 billion from an already unmanageable £6bn in 2017/18. This is work that should already have taken place, and does not include planned maintenance work.

Again the allocations are deceptive. While the DHSC was allocated £7.1bn capital in 2019-20, NHS providers' share of that was just £4.5bn. This has risen from an even more inadequate £3.9bn in 2018-19 – but was just half of the backlog maintenance bill: the allocations are running well below the amount needed even to preserve standards.

Joshua Kraindler, economics analyst at the Health Foundation, warned in March 2019 that: "The capital budget is, in real terms, the same as it was in 2010-11 and as a result, capital investment per NHS worker continues to fall."

So there is no capital for trusts to invest in re-planning the use of their clinical and other space to restore the near-15% loss of front line beds in use since 2019, or to invest in new and improved diagnostics or other services – let alone provide the extra resources needs for mental health, community services or primary care.

Instead NHS England has looked to spend up to £10bn over 3 years on treating NHS patients in private hospital beds – a short-sighted measure that will leave huge unresolved problems and the NHS chronically dependent on private providers.

Same money, different allocation?

However, with no supporting explanation, the Red Book declares that with the minimal increases just announced, the government expects the NHS to deliver a 30% increase in elective treatment by 2024-25. It also lists a series of ways in which the same money is supposed to be spent:

- £4.2 billion by 2025 "to make progress on building 40 new hospitals by 2030 … and to upgrade more than 70 hospitals". Everybody knows £4.2bn is nowhere near enough. In fact all of the prioritised new hospital projects are at a standstill, with new limits on spending causing chaos. The invitation for bids for an additional eight new hospital projects to bring the total to 48 has resulted in an additional barrage of hugely expensive, unaffordable schemes. And a string of 1970s-built hospitals across the country are increasingly unsafe as concrete planks crumble, requiring hugely expensive stop-gap measures, and threatening to collapse on patients and staff.
- £2.3bn by 2025 to "transform diagnostic services with at least 100 community diagnostic centres …". However the first such community diagnostics centre, recently opened in Somerset, turns out to be yet another project reliant on the private sector. It is being run by Rutherford Diagnostics Limited, in partnership with Somerset NHS Foundation Trust. Peter Lewis, chief executive of Somerset NHS Foundation Trust, told the local press: "We entered into our partnership with

Rutherford Diagnostics Limited in June 2020 because, despite our investment in MRI and CT scanners, and our continued use of mobile scanners, we were concerned that our trust would not keep pace with demand for diagnostic tests in the future." For similar reasons it's likely most if not all of the new centres will also expand the use of private companies.

- £2.1bn by 2025 for "innovative use of digital technology" – another door opened for expensive whizz-kiddery and unproven apps and systems, with control divided between NHS Digital, NHSX and NHS England.
- £1.5bn by 2025 for "new surgical hubs, increased bed capacity and equipment." This sounds a lot but is equivalent just over £3mn per year per acute trust: and new beds and equipment beg the question of where the staff can be found to allow them to operate properly.
- £450m by 2025 for projects in England's 54 mental health trusts, allegedly to replace dormitories with single en-suite rooms, and invest in new facilities linked to A&E and "to enhance patient safety" – again a pathetically inadequate amount to pay the rebuilding and other costs involved.

For mental health as much as acute services the key issue that is taken for granted, and for which no real changes are in hand, is the dire workforce shortage. The Red Book declares, with absolutely no explanation or detail, that the Spending Review settlement "will keep building a bigger, better trained NHS workforce," and reaffirms "the government's existing commitments for 50,000 more nurses".

Staff numbers up... and down

The facts are very different. No appropriate funding has been allocated to pay an additional 50,000 staff. The 50,000 target included an ambitious number of overseas recruits – many of whom, especially from the EU, have been deterred by Priti Patel's ongoing 'hostile environment'. It also included retention of 19,000 existing staff – while anecdotal evidence suggests demoralised and burned-out staff are leaving.

The most recent workforce statistics (July 2021) show that while nurse numbers have increased overall by 11% since July 2010, and midwife numbers by 13%, health visitor numbers are down by 19%.

Mental health nurse numbers are down by 2,350 (5.6%), despite the promise by Theresa May's new government in July 2017 that 21,000 new posts would enable the mental health workforce to treat an extra million patients a year. In 2013 there was 1 mental health doctor for every 186 patients accessing services: by 2018 this had fallen to 1 for every 253 patients. No wonder NHS England admitted last month that 1.5 million patients need mental health treatment but cannot currently get it.

The most recent figures, to June 2021, show a total of 94,000 (7.2%) unfilled posts in England's NHS: of these almost 39,000 are nursing posts, with vacancy rates ranging from 8.4% (South West) to 12.5% in London. Almost 10,000 medical posts are vacant. Almost 10,000 medical posts are vacant.

But the stress on the staff still in post has also been massively increased by the high level of sickness absence, worsened by Covid and the stresses and strains it has put on exhausted teams: anxiety/stress/depression/other psychiatric illnesses is consistently the most reported reason for sickness absence.

As Roy Lilley recently pointed out in his critique of the Spending Review: "There are three NHS issues that must be resolved before anything else can be done, developed, extended, organised, planned, expanded or improved … workforce, workforce and workforce."

In need of support, not empty promises

But with no investment to pay for recruitment of extra staff, a miserly 3% pay award this year effectively cutting the pay of existing staff, and an empty promise of lifting the freeze on public sector pay … next year, with no commitment to fund any increase, it's quite clear ministers haven't got the message.

Empty boasts of more and better trained staff, new hubs and centres, new hospitals and increased levels of elective treatment therefore stand in jarring contrast to the dire state of today's NHS, with ambulance services stretched to the limit while crews queue for hours to hand over emergency patients to rammed-full A&E departments; hospitals with sharply reduced capacity grapple with emergencies, Covid and the waiting list backlog; staffing levels often plunge below safe limits – and primary care services, mercilessly attacked by ministers, right wing news and social media, somehow manage to deliver record numbers of consultations despite reduced numbers of GPs and years of broken promises.

Yes the NHS is spending record amounts; yes there have been increases – but it's facing record levels of demand, and the increases are not enough.

Until enough NHS managers pluck up the courage to speak truth to power, and opposition MPs, campaigners and unions mobilise to publicise the dangers – and force enough back bench Tories to recognise the real state of play, it won't get any better. NHS patients need staff, quality care and support, not lies, damn lies and statistics.

John Lister

Safety issues scrutinised as more patients pay for care

● **An investigation by the HSIB into a patient death has found safety issues in the independent sector**

● **For the first time ever the number of people paying private hospitals directly for care (self-pay) was a third of all private admissions**

● **Previous recommendations to increase safety in the independent sector have not been acted on**

● **The independent sector continues to work in ways that could jeopardise patient safety**

The safety of the independent hospital sector is once again under the spotlight in a report just released by the HSIB (Healthcare Safety Investigation Branch) - Surgical Care in Independent Hospitals - triggered by the death of a NHS patient sent to an independent hospital for bowel surgery. .

The 58 year old patient of previously good health, had been diagnosed with bowel cancer and was scheduled to receive keyhole surgery at an NHS hospital to remove part of his bowel. As a result of the pandemic, his surgery and all other NHS cancer surgery was transferred to an independent hospital. Here the surgery method was changed to open bowel surgery following guidance on Covid-19 risks.

The patient's recovery post-surgery was slow and after eight days he was transferred to intensive care at a local hospital. A scan showed a leaky bowel which led to sepsis and organ failure. The patients died soon after.

Safety recommendations made

The report made six safety recommendations, three to NHS England and NHS Improvement, one to NHSX, and two to the Care Quality Commission (CQC). These organisations must respond within 90 days.

The recommendations cover communication between the NHS and independent sector, correct assessment of the capabilities and capacity of independent hospitals, the use of standardised care post-surgery, and better assessment for frailty of younger patients.

Waiting lists pushing people to independent sector

This report comes at a time when more and more people are turning to the independent sector due to the waiting lists for surgery on the NHS.

For the first time ever the number of people paying private hospitals directly for care was a third (32.9%) of all private admissions, according to data from the Private Healthcare Information Network (PHIN). The number of self-paying patients, not those funded by insurance policies, was up 30% from April to June 2021, compared to the corresponding period in 2019.

Self-pay is at its highest among 60-79 year olds; not surprising as insurance policies typically do not cover pre-existing conditions so rarely cover older people.

These are patients taking out loans, using savings, or borrowing from family and friends. From April to June 2021, 65,000 people chose self-pay in order to pay for care.

Certain procedures attract more self-pay patients than others, including cataract surgery and hip replacement, which according to PHIN data are both now more commonly self-funded than paid for through insurance.

And the number of people paying for private care is likely to rise still further; a September survey by Engage Britain shows one in five people say they have been forced to use private healthcare, because they couldn't get the NHS treatment they needed.

The NHS also continues to use the independent sector as a means to reduce its waiting list, which now stands at 5.7 million.

Is the independent sector better/safer?

Patients who pay for surgery via self-pay, through insurance policies, or who are transferred to the independent sector by the NHS often have a perception that treatment in a private hospital will be superior. However, this belief of superiority relates almost entirely to aesthetic factors; the hospitals tend to be more comfortable and visually attractive, and you get your own room.

In 2018 a report from the Care Quality Commission (CQC) found that two in five private hospitals were failing to meet safety standards intended to protect the public from harm. This prompted Jeremy Hunt, the then Health Secretary, to give the private providers two weeks to come up with a plan to "get their house in order" on safety and quality or else face tough sanctions imposed by the government.

In 2017, the safety of private hospitals hit the headlines when the surgeon Ian Paterson was jailed for 20 years after being found guilty of wounding with intent after carrying out unnecessary surgery on thousands of women over 14 years.

So did either of these two events change things in the private hospital market? The Paterson scandal led to an inquiry that released a damning report in February 2020 stating that the private healthcare system he worked in was "dysfunctional at almost

every level". However, it's over a year later and the government has yet to make the major changes in the report that would have improved patient safety in private hospitals.

The sector lacks transparency

A major criticism was the sector's lack of transparency. In 2014, the Private Healthcare Information Network (PHIN) was established to bring greater transparency to the private health sector. However, it wasn't until 2020 that the first data on Never Events was published. These events are preventable patient safety incidents of the most serious category (such as operating on the wrong body part or administration of the wrong drug).

Twenty-one 'Never Events' were reported for 2019, but more than 300 hospitals or PPUs were unable or unwilling to hand over the data. At the time the Centre for Health and the Public Interest, a social care and health think tank, noted the lack of data from more than 300 hospitals meant there was a continuing lack of transparency.

Transparency has not improved as the latest data for 1 April 2020 to 31 March 2021 reported 16 'Never Events' from 257 out of 641 independent hospitals and NHS private patient units (PPUs). Although this covers 86% of patient volume in the sector, a considerable amount of information is still missing.

In contrast, all 'Never Events' are reported by the NHS. No unit or hospital avoids reporting them.

The PHIN notes on its website that when looking for a private hospital patients should check whether it is reporting its 'Never Events' and if it isn't, what does this say about safety in the hospital, and what could this mean for your care? And if it has reported Never Events then what type of incident was it, what did they do about it and might this be relevant to your care?

Lack of ICU and staff levels are major safety issues

A major safety issue with the independent hospital sector, as seen in the recent HSIB report, is the lack of intensive care (ICU) beds. The private sector relies entirely on the NHS for access to ICU. A lack of these beds means the hospitals should not carry out surgery on patients in high-risk groups, as assessed using NICE guideline NG45 (2016). As the case investigated by the HSIB shows well however, is that the assessment process is not always accurate and patients may still need ICU. In this case patients are transported to a nearby NHS hospital with the consequent delay in getting the patient into ICU; an ambulance has to be called, then the patient is taken to a hospital with a free ICU bed - this could take under half an hour or it could take much longer. Transfer to ICU in an NHS hospital would be a matter of minutes not hours.

There continues to be an issue in private hospitals linked to the sector's use of Registered Medical Officers (RMO) to look after post-surgery patients. An RMO is generally at the start of their medical career and will lack experience of all of the various conditions and complications that can occur among their patients. An RMOs contract usually requires them to be on-site at a specific hospital at all times, but they are often the only doctor on-site outside office hours.

In June 2021, the GMC published a survey of RMOs working in the UK private sector. They found that RMOs face challenges in the form of high workloads, struggling to reach senior colleagues for support with patients, lack of time for training, and high levels of responsibility. The survey revealed that around half (47%) of RMOs could "recall witnessing a situation in which they believe a patient's safety or care was being compromised when being treated by a doctor."

RMOs working in the private sector are supposed to receive supervision and mentoring, however many were not impressed by the quality. A sizable minority (29%) felt that supervision was poor and a higher proportion of RMOs felt the quality of mentoring they received was poor (39%).

Safety can also be compromised by what many think of as a benefit of private healthcare - a private room. You will be checked periodically but you are not easily observable, whereas NHS patients are usually placed in wards or small bays where the beds are separated by curtains, where you can be easily observed. Patients at-risk of deteriorating are likely to be closer to the nurse's station.

Who monitors the sector?

As in the NHS, the independent sector is monitored by the CQC. It was this organisation's report back in 2018, and the Ian Paterson scandal, that prompted a closer look at the sector. Hospital ratings are available on the CQC website and many of the independent hospitals continue to be rated 'Requires Improvement' although site visits took place back in 2016/17/18.

When asked, the CQC told The Lowdown that there is monitoring of the hospitals that received low ratings and an action plan is drawn up for improvement. In cases where a provider has breached the legally enforceable regulations the CQC does have a range of enforcement powers to ensure improvement and keep people safe.

The HSIB report has given the CQC more to do on the safety of the independent sector with two recommendations: developing ways to monitor the lines of communication between the NHS and the independent sector to avoid confusion of responsibility and that the regulation of integrated care systems includes ways to check and monitor the surgical pathways between independent providers and the NHS.

Ambulance crisis: who is rushing to help?

The past two months have provided ample evidence – if any more was really needed – that ambulance services across the UK are struggling to cope with the impact of rising demand awhile A&E departments were operating at full capacity, causing crews to be held up for hours waiting to do handovers.

– One patient died in the back of an ambulance, while waiting outside Addenbrooke's Hospital in Cambridge to be handed over to A&E staff, while a pensioner died after a 40-hour wait for an ambulance to turn up in Glasgow.

– Another pensioner, in Oxfordshire, was left on floor of his house for more than five hours waiting for an ambulance. A second call to 999, after an hour, had to be diverted to a call centre in Yorkshire because the local service was too busy.

– South Central Ambulance Service, which covers Berkshire, Buckinghamshire, Hampshire and Oxfordshire, Sussex and Surrey, citing "extreme pressures", declared a 'critical incident' (ie where the level of disruption results in an organisa-

tion being unable to deliver critical services) across the region and urged people to only call the emergency services about life-threatening illnesses and injuries.

– West Midlands Ambulance Service (WMAS) nursing director Mark Docherty told the Trust's board that handover delays were causing the service to raise its risk category to the highest level for the first time as "we know patients are coming to harm" because of those delays, and that some patients were "dying before we get to them".

– One WMAS crew waited 13 hours to hand over a patient at the Royal Shrewsbury Hospital in October, and the service lost almost 17,000 hours due to handover delays in September, nearly three times as many as a year earlier.

– At the same time the BMA released data showing the number of patients waiting over 12 hours in corridor trolley beds for admission increased to a record high.

– And north of the border, the Scottish Ambulance Service called for military assistance from the Ministry of Defence to support paramedics to help it cope with "unprecedented" pressure on the NHS.

Short-term solutions not the answer

Just hours after WMAS raised its risk category, NHS England's (NHSE) medical director wrote to ambulance trusts and hospitals across the country urging them to "immediately stop all ambulance handover delays", saying that 'corridor care' was unacceptable and that ambulances should not be used as A&E cubicles.

Among the initiatives NHSE has suggested might address the handover delay problem – 35,000 patients are said to have waited more than an hour in ambulances in September – was the creation of separate units at hospitals specifically for patients being assessed for admission from A&E. This was an idea first mooted in Scotland in September, although questions were raised at the time over patient safety considerations.

Nevertheless, last week the Evening Standard (ES) ran a piece on just such an initiative – an airport-style 'arrival lounge' being trialled at Queen's Hospital in Romford, managed by existing A&E staff alongside London Ambulance Service (LAS) paramedics working in an unused part of the site, thus allowing patients to be monitored while waiting to be seen.

Insane idea

However, a few days later the Daily Mail quoted one concerned A&E consultant describing the arrival lounge idea as "beyond stupidity and verging on insanity", and claiming that without funding for extra staff to run such facilities would lead to patients dying.

Other short-term responses to the crisis have surfaced – the ES paper also suggested LAS was reintroducing the deployment of paramedics in cars or on bicycles and motorbikes to enable them to attend more incidents – but the crisis calls for much longer-term structural and funding solutions.

NHSE's announcement back in July of an extra £55m award to ambulance trusts to boost staff numbers ahead of winter, and to "improve performance", may go some way to easing the handover delays, but the cash may not stretch far enough, and does nothing to address issues like bed-blocking or pandemic-related staff burnout.

The Royal College of Emergency Medicine has said 1,000 extra hospital beds are needed in Scotland alone to relieve the bottlenecks experienced at A&E.

And In March this year the charity Mind Cymru published a survey which found that mental health had worsened across all the 999 services, but that ambulance staff were the worst affected.

Only one in three ambulance staff reported their current mental health as being very good, and last month Welsh Ambulance Services NHS Trust revealed that around 50 people a day – out of a frontline workforce of 3,000 – were absent because of stress and anxiety, largely caused by the difficulties experienced waiting outside hospitals.

Unions call for better support

Recent figures show that in the past two years the number of 'category one' (ie life threatening) incidents have risen by more than a quarter, and overall ambulance activity was up by 10 per cent – July this year was the busiest ever for ambulance services, with more than a million 999 calls – but nationally there's an annual funding gap for these services of more than £200m.

The crisis in ambulances services has been brewing for years. As long ago as April 2018, the Observer conducted a survey of the ten NHS regions and found that ambulance services across England were already short of nearly 1,000 frontline staff, with LAS recording the highest tally of unfilled posts. Unsurprisingly, in early 2020, the Care Quality Commission downgraded LAS' safety rating, citing concerns that the service had too few staff to answer 999 calls consistently.

The situation had inevitably a huge cause for concern in unions representing paramedics and support staff. Earlier this year Unison wrote to the Association of Ambulance Chief Executives highlighting unsustainable demand, and suggested that "the only long-term solution to the crisis for the ambulance services is continual investment in the workforce to deal with the demand".

Martin Shelley

New fight against Grantham Hospital downgrade

Once again doubts have been raised over the future of emergency and acute in-patient services at Grantham Hospital as a fresh consultation has been opened by Lincolnshire CCG on plans which would permanently downgrade Grantham and centre services elsewhere.

However the validity of the consultation, which is not due for completion until late December, is called into question by the subsequent announcement that United Lincolnshire Hospital Trust has plans for a multi-million investment to double the size of Boston A&E.

While this is good news for Boston area residents SOS Grantham Hospital campaign notes that it is "a slap in the face for 120,000 people in the Grantham and District Hospital area," who are to see their A&E downgraded to an Urgent Treatment Centre and other acute services lost. For the past five years Grantham residents have seen emergency ambulances drive past their hospital at night since the night closure of the Grantham A&E unit, and the proposed Urgent Treatment Centre – even if it is open 24/7 as promised – will not replace an A&E unit.

SOSGH, which has launched a new online petition to stop the downgrade of Grantham Hospital, asks "How can ULHT staff the doubling in size of Boston A&E, and associated admissions, when Lincolnshire CCG and United Lincolnshire Hospital Trust are telling us there aren't enough doctors and consultants in the county to keep all our A&E and other acute services going?"

They fear local children and babies, elderly, and acute stroke patients will be particularly affected. However NHS decision makers are "already committed to taking key staff and services from Grantham and diverting them elsewhere in the county." They took no notice of a 2019 SOSGH petition of 33,000 signatures opposing any A&E downgrade.

According to the CCG's own figures current CCG and ULHT plans will put over 700 lives in the Grantham area a year at risk, although campaigners argue this is an underestimate, given how many acutely ill patients had to travel for treatment when Grantham A&E was closed last year at the peak of the Covid 19 pandemic.

But the scale of the problem is likely to increase. Council growth plans would mean over 7000 more households would be moving into Grantham and the surrounding area which is a virtual black hole as far as maternity, trauma and acute emergency services are concerned, after a decade of NHS strategic decisions.

Lincoln A&E, already overloaded, would be required to cope with even more patients causing further pressure on staff and delays for all patients and ambulance crews affected. Improving A&E services at Lincoln or Boston will do little to make up for Acute services lost in Grantham. Too many critically ill people here will arrive in a worse condition or not survive the cross-county journey.

"The CCG have a duty to care for us all, based on medical need. Our critical needs will be ignored. This includes Grantham area emergency stroke care needs which do not even get mentioned in the latest poorly worded Acute Service Review report," says SOSGH.

"We are not alone. Social media messages from other residents across the county indicate that others are also unhappy with the CCG plans. … We are delighted to be working with fellow campaigners in Is anyone Listening Lincolnshire? and Fighting for Life Lincolnshire."

The new petition and more details of the campaign are available online and available for download.

John Lister

A history of privatisation part 7: A flurry of contracts and "reforms"

After New Labour's third and final election victory in 2005, a new Health Secretary, Patricia Hewitt, lost no time in cranking up more privatisation. She invited private tenders for a second round of "Independent Sector Treatment Centres," (ISTCs) to deliver a further 250,000 operations a year, worth an estimated £500 million annually: but NHS hospitals – even Foundation Trusts – were excluded from the bidding process..

In addition another £400m worth of X-rays, scans, blood tests and pathology tests were to be hived off to the private sector.

The Department of Health (DoH) no longer claimed that ISTCs were being brought in to create additional capacity. Instead the establishment of a viable private sector was seen as a means to establish "contestability," which in theory was supposed to drive up standards and drive down prices.

So waiting list operations would be transferred from NHS hospitals to private providers (leaving under-used NHS departments with inflated costs and a caseload of complex, chronic and costly patients the private sector did not want).

Indeed, because the services were being transferred, the DoH argued that it should also allow the transfer of NHS staff to carry out the work – permitting them to be seconded from NHS hospitals. Publicly-owned NHS Treatment Centres and facilities were also likely to be handed over to private operators, although an effort to do this in Epsom Hospital was successfully blocked at the last minute by campaigners [see box].

The new contracts would almost double the number of private sector operations to be purchased by the NHS, pushing the government 's total spend in the 'independent sector' up towards £1.5 billion – two thirds of the total £2.3 billion turnover of the private medical industry in 2003.

The plan was no longer an 'internal' market – but simply a market, in which NHS Trusts would have to compete not only against other NHS Trusts, but also against private hospitals which have a much more selective – and thus much less complex and costly – caseload, and no emergencies to deal with.

So, bizarrely, NHS hospitals, under the cosh to deliver endless year-on-year 'efficiency' savings, were now told they would be allowed to spend taxpayers' money on advertising to attract patients.

The pace of the competition was to be forced by putting the responsibility on to individual patients, who would be offered a progressively wider 'choice' of where to have their treatment, but not made aware that the potential consequences of their decisions could include forcing the closure of their own local NHS hospital.

By the end of 2005 Primary Care Trusts (the local commissioning bodies) would be obliged to offer almost all elective patients a 'choice' of providers – including at least one private hospital – from the time they were first referred. PCTs would also be required to ensure at least 10% of elective operations went to private providers.

In early 2006 New Labour plans were suggesting a long list of NHS-owned and run facilities should be handed over to private companies as part of the drive to ensure at least 10% of all NHS elective work was delivered privately, rising to at least 15% in the longer term. They included:

- A brand new state of the art NHS Treatment Centre in Birmingham, not even yet open;
- A specialist unit in the new PFI-financed New Forest hospital in Lymington;
- A huge renal dialysis contract covering much of the north of England, with dozens of NHS units handed over for private operators to refurbish and run for profit.
- NHS catheter laboratories in Rotherham and Barnsley, which could be handed over as part of a cardiology contract:
- "Spare surgical capacity" in NHS hospitals in the South West Peninsula could be used by private companies carrying out NHS-funded operations;
- Modern NHS treatment centres, including Ravenscourt Park Hospital in north-west London and the world-leading South West London Elective Orthopaedic Centre (SWLEOC)

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in Epsom also faced the threat of privatisation.

None of the planned Treatment Centre projects were put out to public consultation, and patients remained largely unaware of the plans or their implications, making them harder to challenge.

One plan rejected

In summer 2005 Epsom & St Helier hospitals NHS Trust which runs SWLEOC placed an advert in the official EU Journal inviting private companies to bid to take over its management from Spring 2006. This decision was not taken by the Trust, but at national level by the Department of Health.

In September 2005 plans were revealed to hand over SWLEOC to a New York-based Hospital for Special Surgery. The UNISON Branch in Epsom & St Helier Trust worked with pressure group London Health Emergency to mount a challenge to the proposals.

It was finally halted when a small group of noisy local pensioners and LHE organiser Geoff Martin managed to get in to the trust board meeting that was to sign off on the deal, and ask the killer question: where was the business case to show the benefit of the deal to the NHS?

This was met by a constipated silence from trust chair, finance director and board members, none of whom had obviously even asked the question. They adjourned the meeting promising to return with an answer, but in fact returned only to move on to next business – and the privatisation had been abandoned. SWLEOC is still a highly successful NHS-owned and run unit 15 years later.

Choice agenda

From 2008 any patient would be allowed to choose any hospital which could deliver treatment at the NHS reference cost, erecting 'patient choice' as a more fundamental principle than maintaining local access to NHS hospital services, with Tony Blair stating: "Choice is not a betrayal of our principles. It is our principles."

Alongside the privatisation came a renewed financial squeeze on NHS trusts, which began almost as soon as the votes had been counted in the 2005 General Election on May 5. The first cuts in hospital services began to hit the headlines locally and nationally: Lewisham Hospital in SE London revealed an £8.5m deficit and plans for ward closures.

Hewitt clearly believed that the instability her government's policies had created was good for the NHS. In a June 14 interview with the Financial Times's Nick Timmins, she admitted that too many NHS staff feel that "change upon change has been done to them, rather than with them", but spelled out the scenario: "It's not only inevitable, but essential that payment by results and these other elements create instability and change for the NHS. That is precisely what they are designed to do."

The logic of Hewitt's position was simple: any hospital that failed to balance its books must have failed to attract sufficient patients – and patients had therefore exercised their 'choice'. Since patient choice was the main mantra of New Labour's NHS policy, those hospitals which were not chosen would be allowed to close.

But there was no equivalent promise to patients whose first choice was to use good services at their local NHS hospital, but who faced being dispatched for private sector treatment to meet new privatisation targets.

Crisp provokes a crunch

July 28 2005, normally the midst of a sleepy holiday period, marked the launch of a round of restructuring and "reforms," unveiled in a circular to NHS managers by NHS Chief Executive Sir Nigel Crisp. Although Crisp and ministers claimed that the reforms were "to reflect patient choices" and reshaping 'from the bottom upwards', the opposite was the case: the reforms were being relentlessly driven from the top, with no heed for critical views from professionals or the public.

Opinion polls and surveys confirmed that the first choice of NHS patients was the opposite of government policy: people wanted continued access to comprehensive local NHS services in the hospitals they knew and loved.

Crisp's plan meant the Primary Care Trusts (PCTs) which held the purse strings for most health care services, and still directly employed upwards of 250,000 health workers delivering community and mental health services, would have to be broken up, and reduced to commissioning only. Their services were to be hived off to Trusts, handed over to the voluntary sector, or simply contracted out to private firms. Crisp clearly didn't care which.

The process of restructuring was designed to cut spending on NHS hospital care, diverting more patients to private providers, and encouraging GPs and PCTs to "free up" cash by developing alternative forms of "care outside of hospital".

Angry trade unionists joined with frustrated and befuddled Labour back-benchers to protest at Crisp's scheme, which had been hatched up by a few back-room mandarins and health ministers without any wider discussion. After months of protests and pressure some of the more outlandish proposals were toned down, postponed or dropped: Patricia Hewitt even came to a UNISON seminar and apologised for having got it wrong.

In Oxfordshire, a proposal to hand over responsibility for commissioning and control of Oxfordshire's health budget to a private company (believed to be leading US insurance corporation UnitedHealth) generated such a unanimous tide of local protest that ministers were eventually obliged to step in and call a halt to the experiment.

Fighting back

The situation was clearly serious, and in the Autumn of 2005, in response to this gathering pace and scope of privatisation – which included moves to give contracts to run GP services in the Derbyshire coalfields and in North London to the British subsidiary of UnitedHealth – a new campaigning organisation, Keep Our NHS Public (KONP) was set up.

KONP was the result of an initiative by Professor Allyson Pollock, with resources from the NHS Consultants Association, London Health Emergency and the NHS Support Federation, and backed by many activists and academics.

Its initial statement warned: "The NHS stands at a crossroads. For nearly 60 years Britain has enjoyed a National Health Service that is comprehensive, locally accessible and exceptional value for money. Now, government reforms threaten both the ethos of the NHS, and the planned and equitable way in which it delivers care to patients."

As if to vindicate the decision to launch the campaign, the Commons Health Committee, in a hard hitting report in December 2005 expressed itself "appalled" at the lack of clarity over the future of services provided by PCTs.

Ignoring the Committee's concerns, Hewitt in January 2006 published a new White Paper Our Health, Our Say … seeking to push Primary Care Trusts towards "outsourcing" of all services: it contained a provision for local service users to petition to force their local Primary Care Trust to put any public sector NHS service out to competitive tender from "any willing provider".

A month later Hewitt went further, and claimed at a press briefing that PCT staff were eager to be privatised! She asserted there was 'widespread enthusiasm' from staff to move out of the NHS and work for social enterprises in primary care and, according to the HSJ: "called for 'unions and professional bodies to start to see it as something which their own members are very interested in…'."

On February 16 2006 – hard on the heels of a major contract failure (the shambolic hand-over of the supply of bottled oxygen to vulnerable patients at home to four profit-seeking companies, with predictably disastrous consequences) – Tony Blair personally staged a formal "welcome" into the "NHS family" … for eleven profit-hungry private companies.

Blair gleefully predicted that the NHS would soon be purchasing up to 40 percent of private operations. In some areas and specialties this would mean private providers creaming off a majority of routine surgical cases from NHS Trusts: this would not only have a financial impact, but would strike a body blow at the training of junior doctors, and at medical research which is only carried out in major NHS University hospitals.

Rationing NHS care

The summer of 2006 saw panic measures in London to ration numbers of patients referred by GPs to hospital consultants. News of the privately-run, cash-led rationing scheme, which would process each GP referral through a team of bureaucrats in "referral management centres" broke with the publication of a leaked document, in which managers discussed measures that would arbitrarily restrict Londoners to the lowest 10% of hospital referral rates anywhere in England.

A critical article in the British Medical Journal argued that the principal aim of the new centres was to "curtail demand" and underlined the lack of any evidence that the new system, which had "appeared overnight in an evidence-free zone" could deliver any positive benefit for patients.

It was obvious some of the patients denied NHS elective care would "choose" to go private.

Also in the summer of 2006 ministers provoked fury by inviting private insurance companies to take over control of a large slice of the £64 billion NHS commissioning budget controlled by PCTs. The first inkling of this proposal came in a front page article in the Financial Times, headlined 'Insurers invited into NHS economy'. FT correspondent Nick Timmins concluded that:

"The move is likely to attract interest from the big US insurers such as United Health and Kaiser Permanente, Discovery of South Africa, BUPA, PPP and Norwich Union in the UK, and possibly German and Dutch insurance funds."

These insurance companies specialise in screening out and excluding potential subscribers with pre-existing illnesses and chronic conditions – and have no relevant expertise that could

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inform the commissioning of a comprehensive health care service for the whole resident population of a PCT.

It seemed the whole story was a 'kite-flying' exercise to test out public response … until it was revealed that an advert had indeed been placed that week in the Official Journal of the EU, inviting companies to bid for 'framework contracts' to deliver commissioning and management services to PCTs. Virtually all aspects of the PCTs' role were to be offered out to private bidders: "This will include, but not be limited to, responsibility for population health improvement, the purchasing of hospital and community care, supporting local GPs develop practice-based commissioning [sic], the management and development of community health services for the PCT resident population …."

The new arrangement would leave the PCTs with next to nothing to do other than brew the tea and open the biscuits for occasional board meetings.

However once again, as it had been the previous autumn, the advert was suddenly withdrawn, with claims of unexplained "drafting errors", and a letter from Hewitt was hastily published, attempting once again to assure an even more confused and sceptical public that there was no plan to privatise the NHS. But the very next month ministers gave the go-ahead to a fresh advert, identical in all essentials.

Also in 2006 a high court judge rejected local appeals and rubber-stamped a bizarre tendering process which had allowed UnitedHealth Europe to secure a contract to deliver primary care services in rural Derbyshire, despite having no staff, track record, expertise, or local links. The primary care market was already estimated to be worth upwards of £150m a year to the independent sector, with almost a third of Primary Care Trusts planning to put services out to tender.

To cap it all ministers were forcing through the biggest and one of the craziest privatisations of the lot, the carve-up of the award-winning (and profitable) NHS Logistics, the public sector organisation that was in charge of more than £4 billion of NHS procurement budgets – handing the contract to Texas-based Novation, a company under investigation for overcharging the US federal government for health supplies.

In October 2006 the Department of Health implementation document Making it Happen stressed the need for "better partnership working with third and independent sectors". In July a policy paper from the "Third Sector Commissioning Taskforce" emphasised that: "delivering health and social care services is no longer the preserve of the public sector … third sector as well as private providers have a valuable role to play …."

Health minister Lord Warner warned that local NHS hospitals would have to "face up to the need to reconfigure services" to enable new "independent sector providers" to enter the NHS market.

The logic was simple enough: to make room for the development of a brand new private sector, Hewitt, Warner and Blair had to slash back existing NHS services. ***John Lister***

Next instalment: Putting private sector in charge 2007-2009
*Abridged and updated from **The NHS After 60, for Patients or Profits?** published by Libri Press*

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