The lowdown

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

Special report: is privatisation bad for the health of the NHS?

In this issue...

● https://lowdownnhs.info ● nhssocres@gmail.com ● number 40 – 23/02/2021

Under cover of covid

PRIVATISATION THROUGH competitive tendering and outsourcing have been ongoing in the NHS and the public health sector for decades, much to the benefit of corporate interests profiting from this slow 'drip drip' dismantling of the health service..

As revealed in The Great NHS Heist documentary, the Conservative Party was 'wargaming' its plans for selling off the NHS and other public utilities as long ago as 1977, planning denationalisation "not… by frontal attack, but by a policy of preparation for return to the private sector by stealth". Campaigning group WeOwnIt has also noted a 1988 pamphlet from the Tory-linked Centre for Policy Studies thinktank which suggested how profitable the NHS would be for the private sector.

And now, despite plans leaked earlier this month suggesting the government was reversing the controversial market reforms introduced in the 2012 Health and Social Care Act, the privatisation of services that could have been provided more efficiently by the NHS appears to have accelerated 'under the cover of covid' during the past 12 months.

Two reports from the National Audit Office (NAO) published in November last year offer incontrovertible evidence of how this has played out, covering a period when new covid-related contracts worth a staggering £17.3bn were awarded, and the use of emergency procedures meant that £10.5bn worth of these contracts were awarded directly to companies without any open competitive procedure taking place

Firmly embedded

The Conservative Party's default stance on public procurement – to spend extravagantly on private contractors while sidelining existing but underfunded NHS resources – has been on display right from the early days of the pandemic, with high-value contracts awarded to commercial partners (occasionally linked to Tory politicians) under circumstances of minimal transparency, and with no commitment to ensuring these arrangements are not carried forward once the crisis has passed.

Indeed, as the Guardian discovered last year, the head of one

of the key, long-standing beneficiaries of the Tory government's taxpayer-funded largesse – Serco's Rupert Soames – was already privately suggesting that the pandemic could go "a long way to cementing the position of private sector companies in the public sector supply chain".

Even before the pandemic began, analysis by the House of Commons Library in July 2019 – six months after health secretary Matt Hancock had assured MPs that there would be "no privatisation of the NHS on my watch" – revealed that private healthcare firms like Virgin Care and the Priory Group had raked in more than £9bn from the NHS' budget in 2018, up 14 per cent from the equivalent 2014-15 figure.

We pay, you fail

More recently, the total outlay on covid-related contracts awarded to private contractors over the past year may not become clear for some time – the successful legal challenge by the Good Law Project last week over the government's failure to publish contract details within 30 days has yet to bear fruit in terms of new statistics – but information already in the public domain offers ample evidence of the commercial sector doing very well indeed out of the NHS despite that sector's record of failures and underperformance.

Last month the Guardian reported that Medacs Healthcare, a company linked to the Tory donor and former Conservative Party treasurer Lord Ashcroft, had scooped a £350m contract with the DHSC to supply laboratory staff for the government's covid-19 testing operation.

This development follows neatly on from the awarding of contracts of undisclosed value last year to Deloitte, to set up and run drive-in testing centres – which soon became the focus of media coverage when test results for NHS staff were lost – and later to co-ordinate the new Lighthouse laboratories which effectively bypass the NHS' existing network of 44 labs across the UK.

(With regards to the latter contract, a related development took place in October last year, when the South East London Clinical Commissioning Group [CCG] entered into a £2.25bn 15-year deal with private company Synlab to take over its pathology network contract.)

Deloitte has also played a leading role during the pandemic in the sourcing of PPE items such as gowns, masks and visors. Supplies of these items – responsibility for which has mostly been outsourced in recent years – have frequently been in short supply across the UK during the past 12 months, and have often proved to be useless (thereby "wasting hundreds of millions of pounds", according to the NAO reports).

Serco, of course, is the standout example of a private contractor repeatedly being awarded NHS contracts despite a long record of underperformance.

In 2012 it admitted presenting false data on 252 different occasions to the NHS on the performance of its out-of-hours GP service in Cornwall. In 2018, it was revealed that staff at the Serco-run breast cancer screening hotline were not medically trained and had to use 'cheat sheets'. The following year the company was fined £22.9m over fraud and false accounting allegations in relation to electronic tagging contracts with the Ministry of Justice.

Yet last October shares in Serco soared by 18 per cent on the back of profits from its latest contract – thought to be worth almost £410m – with the Department of Health & Social Care (DHSC) to take part in the privately managed test-and-trace set-up (in which it has again been accused of hiring staff with no medical training).

In the same month, it was reported that staff from the Boston Consulting Group (BCG), which also has its nose firmly in the £22bn test-and-trace trough, were said to be earning more than £6,000 a day.

Damage already done

But only last week a report from the DHSC itself revealed that contact tracing – a major element of the test-and-trace operation – has had only a minimal impact (barely 5 per cent) on curbing the spread of covid-19, and that self-isolation alone was responsible for the majority of transmission reduction.

Equally questionable was the awarding of a contract to Capita – reported in 2019 to have mistakenly archived 160,000 patient records under an earlier contract with NHS England, and to have been stripped of a contract to run cervical screening after it failed to send out appointment invitations, reminders or results – to help the NHS recruit retired nurses and doctors last year.

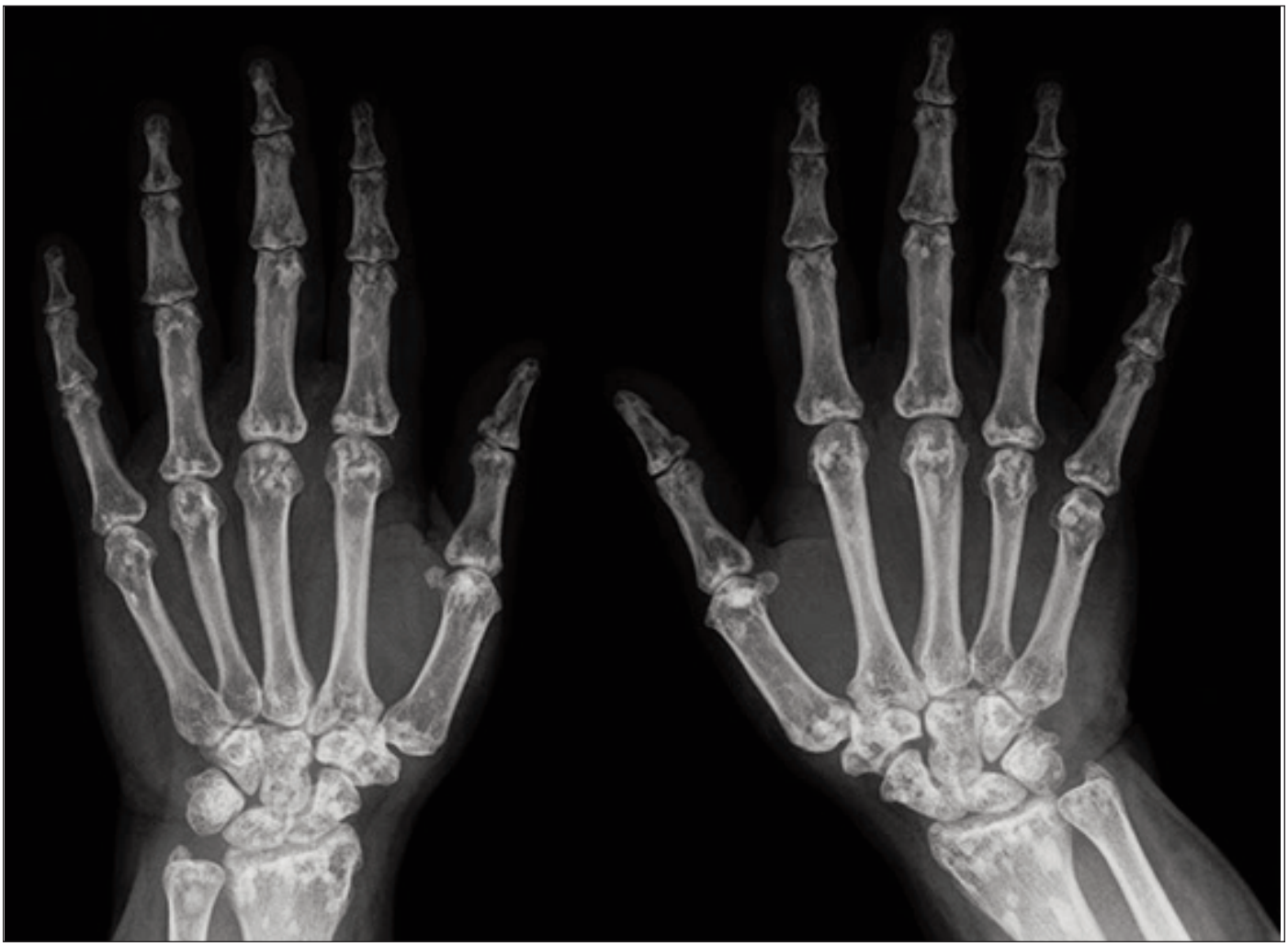
The NHS is already heavily dependent on the private sector. Some CCGs spend more than 20 per cent of their budgets with non-NHS providers. A significant number of non-urgent operations and surgical procedures are already carried out on behalf of the NHS by private contractors. And the health service is on the verge of signing a four-year deal with private hospitals to help it deal with a huge, post-covid backlog of work.

Given that outsourcing is clearly being used to fill gaps in NHS provision created by years of underinvestment – the public health grant in England is estimated to have suffered a £1bn real-terms cut since 2015/16 – none of the healthcare covered by existing or already agreed new contracts is likely to ever return to the NHS, even under the latest leaked plans from the DHSC.

Martin Shelley

For an in-depth analysis of NHS outsourcing and contract failures pre-pandemic, check out our 2013-19 review here.

Why does NHS privatisation matter?



KEY ARGUMENTS IN BRIEF:

- The NHS is open to all patients, whereas private companies will restrict access to protect profits and abandon NHS contracts when their profits fall, leaving the NHS to pick up the pieces
- Public funds spent with private companies flow out of the NHS and lead to underinvestment in the NHS staff and equipment
- Studies show that outsourcing is associated with lower quality care and poorer access and can be unsafe. And yet some companies are still contracted despite their poor track record
- Staff terms and conditions are less protected, continuity of care is more difficult, and outsourcing offers the public care that is less accountable and poorer value
- Outsourcing can help patients where NHS care is not available but, overall, the evidence shows that the NHS provides better value and fuller access to high-quality care

Why it matters now?

Exhausted NHS staff are trying to respond to record waiting lists but are seriously impeded by a long-term crisis in staffing, that includes over 90,000 vacancies. .

This is eyed by the struggling private health industry as a golden opportunity to revive its fortunes. A multi-billion 4-year deal with private hospitals is in the pipeline and could see a big surge in NHS patients treated in private units.

And of course, care must be found for all NHS patients, but if this deal and others like it divert sorely needed investment in the NHS, then the reliance on the privateers will grow and NHS capacity will remain far too low.

Important questions about the safety of post-operative care in private hospitals and the value of the contracts hang unresolved.

Meanwhile, ministers have by-passed NHS and public health facilities in favour of signing up commercial outfits to run the £23bn test and trace programme, and are withholding information about a host of other covid deals signed with the private sector.

Investigations have already unearthed cronyism in the signing of deals and evidence that some of the companies chosen lack any relevant business experience.

Under the cover of the pandemic NHS privatisation is rising, along with damaging consequences.

Privatisation compromises the NHS

Professor Stephen Hawking, lived with motor neurone disease for more than 50 years using the NHS throughout, and wrote in the final years of his life that the NHS is "the fairest way to deliver healthcare". The mission of the NHS is to deliver comprehensive care to all in our society, prioritizing those with the greatest clinical need. Private companies may claim to support these aims, but in practice the drive for profit places limits on the care they will offer. Fundamentally, the commercial strategy will always diverge from the aims of the NHS.

Threats to patient safety

The record of NHS outsourcing has been tarnished by a catalogue of instances of harmful cost-cutting and the delivery of substandard care. Here's three examples:

Cygnet, a specialist mental health provider that operates more than 150 facilities across the UK, has been repeatedly criticised by the Care Quality Commission (CQC). In September 2020, an unannounced inspection of Cygnet Yew Trees, a facility for women with learning disabilities, found evidence of staff "abusing patients, acting inappropriately or delivering a poor standard of care".

A private hospital run by BMI Healthcare that treats up to 10,000 NHS patients a year, put their safety at risk according to a report by the health watchdog. The CQC rated Fawkham Manor hospital in Kent as "inadequate" – the worst possible ranking. Staff told the health watchdog that financial targets were prioritised over patient safety at the hospital, where NHS patients make up almost half the caseload.

DMC Healthcare had several contracts for GP surgeries in the Medway area. However, when the Care Quality Commission found serious concerns with the quality of healthcare. enforcement action was taken, and the company was removed from running five surgeries and suspended from three others.

Further examples of the failures of outsourced services are available here.

Price competition lowers quality

For non-clinical services like cleaning and security, where price competition is allowed, commercial providers can win contracts by underbidding competitors, but to keep to the price, quality often suffers.

A 2019 study of 130 NHS trusts, looking into the impact of outsourced cleaning services concluded that "private providers are cheaper but dirtier than their in-house counterparts." They found lower levels of cleanliness and worse health-care outcomes, which can be measured by the number of hospital-acquired infections.

A further international study has confirmed the relationship between the quality of cleaning services and the frequency of hospital-acquired infections, with the clear implication that outsourcing cleaning services can threaten patient safety and cost lives.

Staff can be poorly treated

A string of recent disputes over terms and conditions reinforces the message that outsourced staff often get a worse deal than their NHS equivalents.

In Southampton staff working for Mitie Security Ltd went on strike last year over pay, sick pay and a lack of protective equipment, which they need to help deal with regular attacks from the public – often under the influence of drink or drugs. In Doncaster, catering staff employed by French company Sodexo were told that NHS pay levels could not be matched. And in Wigan drug and alcohol workers were forced to strike after their employer Addaction refused to keep pace with NHS pay rates for equivalent jobs.

Porters, cleaners and security staff working for NHS trusts across the country have also been forced to fight and sometimes strike against their NHS employer's plans to transfer them over to "money-saving" subsidiary companies, moves which have

continued on page 6...

...continued from page 5

been vigorously opposed by trade unions as unjust and privatisation by the back door.

Services are less secure

As the use of the private sector expanded it became clear that companies were dropping out of the contracts when profits fell. In these circumstances, the NHS has stepped in, sometimes at short notice and at its own cost to keep the service going, but of course, the continuity of patient care will inevitably suffer.

In Brighton and Hove, The Practice Group terminated its contract for five GP surgeries in the city at the end of June 2016, leaving 11,500 patients looking for a new GP. Over the years, The Practice Group, which runs around 50 GP surgeries, has also closed a surgery in Camden Road, London, the Maybury surgery in Woking, the Brandon Street practice in Leicester and the Arboretum surgery in Nottingham.

All these surgeries were in areas of high deprivation, where it is difficult to make money. The Practice Group defended terminating the contracts and closing services, saying that loss-making activities were unsustainable.

The private sector doesn't share the risk

Private sector providers draw up eligibility criteria to determine which NHS patients they will accept for treatment, and frequently this means the more complex and costly cases end up receiving care in the NHS. This is a feature of health systems with public/private partnerships.

GPs have accused private providers of cherry-picking, by attracting younger patients to their lists. This has left some surgeries struggling with a skewed patient list - a greater proportion of patients who require more care and GP time, but with no extra funding to provide it.

A study of the Scottish NHS found that increased use of the private sector was associated with a significant decrease in direct NHS provision and with widening inequalities by age and socio-economic deprivation.

Privatising diverts resources from the NHS

For the last decade the experiments with competition and outsourcing have coincided with an unprecedented squeeze on NHS funding. Workforce, buildings and equipment have all needed significant investment, to adjust to the rising numbers of older people

and increasing chronic disease, but instead, the NHS was forced, year on year to search for unrealistic levels of savings.

Academic analysis has argued that policies to encourage greater private sector involvement tend to coincide with underfunding of the public sector and are associated with a government trying to progress a privatization agenda, often fired by the belief that firms will cost less and improve services.

Benefits come at a cost

International research has confirmed that any benefits of involving private health care come at a cost. A study that collected evidence across 107 low- and middle-income countries to compare the impact of public and private healthcare providers concluded that the private sector more often violated medical standards of practice and had poorer patient outcomes but had greater reported timeliness and hospitality to patients.

Public healthcare is more efficient

A study by the World Health Organization found that public systems tended to be more efficient than private.

The NHS performs well in international comparisons of health systems.

The experiment with marketization and greater involvement of the private sector has resulted in a rise in bureaucracy and administration costs throughout the NHS.

In systems where public provision is lower, there are perverse financial incentives that add costs and undermine continuity of care. Overtreatment of patients is more common, companies do not share patient information and tests are repeated.

Who pays to train the staff?

The NHS trains most clinical and scientific staff. Some go on to work in the commercial sector, but a larger private health sector is an inevitable drain on the staffing resources of the NHS.

Where private hospitals take on a large amount of NHS surgery it can affect the local NHS hospitals as their surgeons do not get the same mix of cases with which to develop their skills.

Outsourcing is not transparent

The public deserves to know who is providing their care, but often companies hide behind the NHS logo, and patients are not informed that their care has been outsourced to another provider or are not given a choice to remain inside the NHS.

During the pandemic, normal tendering rules have been suspended. Commercial companies with the right political connections have landed lucrative deals with the government, trampling over the normal safeguards.

Ministers are being dragged into the courts to force them to reveal information about a series of dubious covid deals, despite the clear public interest in seeing that funds were properly and wisely spent.

KEY STATISTICS

- In mental health care, the NHS often outsources the care of NHS patients - 30% of hospitals are privately run and 44% of health funding for the care of children goes to private companies.
- One-third of NHS hip operations and a quarter of cataract operations are performed in NHS hospitals.
- National stats show that the NHS spent 11% on non-NHS care, although this figure is an underestimate missing expenditure on NHS-funded social care.
- Locally commissioners spend around 15% on average with the largest spenders allocating up to 26% - source accounts for 2019/20

Outsourcing undermined covid response

Throughout the pandemic, outsourcing has rapidly accelerated and normal safeguards are suspended.

The strategy of bypassing the existing network of NHS labs and the council tracing facilities has caused delays and reduced the effectiveness of these services at a crucial time in the response to the virus.

Healthcare workers reported that they were not provided with adequate PPE, leaving them exposed to the virus.

Serco and Sitel have been awarded contracts (valued at £108 million) to support the government's test and trace strategy and yet centralising contract tracing has consistently failed to reach effective levels and performed less well than public health run services operated by contract tracers with local knowledge.

Eight months into the pandemic Independent Sage group concluded "it's clear that England's find, test, trace, isolate and support (FTTIS) programme is failing, leading the government to rely on a succession of restrictions on people mixing to control the pandemic. The result is that the UK has some of the greatest excess death rates and economic damage anywhere."

Covid contractors include:

– Deloitte to manage the logistics of national drive-in testing centres and super-labs.
– Serco to run the contact tracing programme.
– Capita to onboard returning health workers in England.
– DHL, Unipart, and Movianto to procure, manage logistics of, and store PPE.

Paul Evans

The great consultancy boom – from covid to ICSs

MINISTERS AND NHS MANAGEMENT are becoming increasingly dependent on costly private sector management consultants to do the work that managers and civil servants were previously trained and expected to do as part of their jobs..

The pandemic – and NHS England's insistence on driving through the simultaneous reorganisation into "Integrated Care Systems," bringing fresh dependency on private companies specialising in apps, data and 'population health management' – has brought a massive further growth in the numbers of consultants involved.

Yet new research indicates that the NHS itself spent over £300m on consultancy in 2018/19, despite evidence that management consultants in health care "do more harm than good." Indeed the evidence is that once consultants have been brought in they "keep getting rehired" – despite their failure to improve the efficiency or quality of services.

Test and trace

In the pandemic the current government has turned first and often to consultants for systems that could much better have been run through local government and the NHS. Last August consultancy.uk reported that 16 consulting firms had been awarded coronavirus contracts with £56m. But this was the tip of the iceberg..

In January Health Minister Helen Whately admitted that 2,300 management consultants from 73 different companies (more than the civil servants in the Treasury) were currently working on the lamentable Test and Trace system, with £375m spent on consultancy for this project alone.

Other reports revealed that the consultants were being paid an average of £1,000 per day, and that Deloitte alone had 900 employees at work in test and trace. The Daily Mail estimated the total of consultants and contractors at 2,959. Sky News revealed last October that a 5-person team from Boston Consulting had been paid £25,000 per day helping to "mastermind the creation of the contract tracing systems."

Last autumn, with Test and Trace "barely functional" in the face of a resurgence of the pandemic, reports indicated that hundreds of consultants from KPMG, EY and other firms were being lined up to reinforce the numbers who were already failing so badly. According to The Guardian, the additional consultants were required in areas including programme management, data, project support and supply chain – which might have been expected to already be in place.

NHS reorganisation

Consultancy firms have played a key – and lucrative – role in most of the big reorganisations of the NHS going back at least to 1974.

In recent years, a major McKinsey report commissioned by New Labour shaped many of the cost-cutting policies of NHS trusts and commissioners which aimed to generate £20bn of "savings" after the 2008 banking crash: and the incoming Tory-led coalition from 2010 employed McKinsey to help construct Andrew Lansley's large and disastrous Health and Social Care Act.

In 2016-17 the King's Fund found that management consultants were being used to support the development of STPs in three out of four areas: and firms including McKinsey were employed again and again at a combined cost of over £80m in the long running fiasco of the Shaping a Healthier Future project in North West London before it was axed – only for McKinsey veteran Penny Dash to be installed last year as the chair of NW London's "integrated care system".

In 2019 NHS England paid PA Consulting over £200,000 for a 35-day "function mapping exercise" to work out what NHSE itself was responsible for: last year Matt Hancock's department brought in a team from McKinsey for six weeks at a cost of £563,000 help define the "vision, purpose and narrative" of the new body to replace Public Health England after his announcement it was to be axed.

But these ridiculous smaller projects pale into insignificance against the industrial-scale efforts to streamline the recruitment of consultants to work at local NHS trust and commissioner level with the establishment in 2018 of a 4-year "Framework agreement" with a pre-approved list of 107 companies which can simply be .

The sales blurb, from privatisation enablers NHS Shared Business Services, lists ten specific areas of consultancy that are covered, including: Healthcare Business Consultancy, Leadership & Governance Strategy; Healthcare Service Business & Transformation; Healthcare Innovation & Research; Health & Community. It promotes the Framework as:

"A fully OJEU compliant route to market for the provision of multidisciplinary consultancy services; covering a wide range of specialisms. … Pricing options include day rates and also the possibility to agree innovative pricing models."

The usual big names are all there – PwC, Deloitte, EY and KPMG, along with the US big names McKinsey, Bain and the Boston Consulting Group: but consultancy.uk points out the long list also includes "boutique" consultancy firms and specialist healthcare consultancies, which have a long-standing relationship with the NHS.

"Integrated Care"

England's NHS is being reorganised into 42 Integrated Care Systems (ICSs) with new cash-limited "single pot" funding arrangements: this brings with it pressure to increase spending on private sector management consultants, data and digital providers – and this in turn is facilitated by NHS England's establishment of the 'Health Systems Support Framework' (HSSF)..

The HSSF is a four-year £700m framework "established to provide a mechanism for ICS and other health and social care organisations to access the support and services they need to transform how they deliver care. It focuses on specialist solutions that enable the digitisation of services and the use of data to drive proactive population health management approaches across Primary Care Networks (PCNs) and integrated provider teams."

It follows on from the 2018 management consultancy framework, and offers a pre-approved list of 83 firms, more than a quarter of which are US based, pre-approved for work on ten different "lots."

One ICS which clearly displays the extent to which it is being taken over by costly management consultants is Bedfordshire, Luton and Milton Keynes (BLMK), where the lucky winners of seemingly endless consultancy work are Carnall Farrar, who have pushed ahead with the merger of the three CCGs, and United health subsidiary Optum, whose representative Kane Woodley has a seat on the Partnership Board.

The BLMK ICS Partnership Board papers from September showed Carnall Farrar's determination to press through with the merger of CCGs into a single CCG covering the ICS area, despite the clearly stated opposition of three of the four local authorities at the July meeting.

But they also revealed the extent to which the relative size and influence of the NHS bodies would diminish during the process of establishing the ICS, reducing any vestige of local accountability, and increasing the power and control exercised by Carnall Farrar: "It is expected therefore that the BLMK CCG will reduce in size over time as we implement the co-designed Target Operating Model for the strategic commissioner."

However a progress report by Carnall Farrar in February has revealed just how ineffective their bullying tactics have been in achieving any genuine integration between the NHS bodies in BLMK, let alone with the local government "partners.

And, as the ICS proposals set out in the White Paper are formulated into legislation, potentially entrenching long term and more powerful roles for management consultants, it's useful to remember the warning from the Financial Times in 2017, which drew a thinly disguised analogy between consultants and vermin:

"The … danger is that consultants become a habit — once they get inside the building, they are hard to eradicate. They have an interest in keeping the relationship going, either by persuading clients that the challenges are complex, or by selling them more services."

The more reliance NHS management place on management consultants, the less the focus on patient care and public accountability, and the greater emphasis on "business" methods, markets, profits … and finding new roles for even more private contractors.

A history of privatisation, part 3: 30 years of the internal market

THE GOVERNMENT'S new White Paper setting out its plans for a new top-down centralising "reform" of the NHS presents itself as stepping away from competitive tendering – but explicitly retains the split between purchaser (commissioner) and provider.

We have become so accustomed to the existence of NHS Trusts, and the separation of commissioners from providers within the NHS that it's hard for people in 2021 to grasp what a shock it was when Trusts were first allowed to "opt out" of the control of local health authorities exactly 30 years ago.

Much of the action running up to and following the NHS and Community Care Act of 1990 was reported for campaigners and trade unionists in issues of Health Emergency newspaper, which published 23 issues between the end of 1988 and the general election in 1997.

Margaret Thatcher's "internal market" swung into chaotic action – a year after she had been bounced out as PM. The Act (described in Part 2 of this occasional series) had received the Royal Assent in the summer of 1990.

But there had been substantial resistance to the "internal

market" reforms, and as the first hospitals applied in 1990 to 'opt out' and become an NHS Trust (after a tokenistic 3-month "consultation" period) many were met by a wave of active local anti-opt out campaigns.

These often linked broad sections of the community, reaching from health unions through Community Health Councils, councillors, Leagues of Friends, pensioners groups and broader sections.

Many large, angry public meetings were held. Polls revealed upwards of 70% of the public and 75% of health workers opposed to opting out.

However the government had convinced most senior managers that there was little choice but to seek Trust status, and in December 1990 the first 57 Trusts were announced by the new Health Secretary William Waldegrave, set to opt out of DHA control in April 1991. 120 more hospitals and community units were already lining up with second wave Trust bids. 306 Fundholding GP practices, involving 1700 GPs were also launched, with more expressing an interest.

Two years of debate on market-style reforms to the NHS had triggered some outrageous plans by some local hospital management as part of their plans for "self government" as trusts. "Income generation" wheezes were being hatched up in all directions: QEII hospital in Welwyn Garden City was offering business sponsors the chance to have wards not only named after them but painted out in their corporate colours.

Private patients

Early in 1990 the Sunday Correspondent revealed that Newcastle's Freeman Hospital (which had had to cut back NHS hip operations by 16% for lack of cash) proposed to use "spare capacity" to carry out private operations on patients from Europe, aiming to under-cut the fees charged by BUPA hospitals by up to 50%. .

Similar plans to increase private patient activity at ridiculously low prices were developed in East Anglia hospitals, while Harefield Hospital was also looking for a big expansion of private income and hoping to increase NHS workload "at the expense of other hospitals."

St Thomas's Hospital management were anticipating extra overseas referrals as soon as the Channel Tunnel was completed. In Tunbridge Wells, too, the health authority allocated 13 rooms for private patients – at a fee lower than any private hospital. Great Ormond Street Hospital quoted a price for one operation £3,500 cheaper than a private hospital – leaving more profit for the private insurers.

The new Central Manchester Health Trust launched,

continued on page 12...

...continued from page 11

proudly announcing a new "preferred provider" agreement with a private health insurance firm in an effort to fill unused NHS pay-beds.

By autumn 1991 a new consortium had been launched involving 29 District Health Authorities and Trusts with underused private beds, to investigate marketing "package deals" including travel, treatment, convalescence and even car rentals for wealthy patients from Europe.

Manchester's Christie Hospital offered 26 health authorities the opportunity to buy preferential access for cancer patients, cutting the normal 6-week wait to just two weeks – by paying an extra £10,000-£25,000 per year.

The expansion of NHS pay-beds continued apace: analysts Laing & Buisson reported a staggering 84% increase in NHS private bed numbers in 1992-3; however figures showed 3,000 NHS pay beds had generated an average income of just £92 per day in 1989, while private hospitals were charging up to £400.

Attacking jobs, pay and conditions

The internal market brought a new level of instability and desperation to the new trust managers. Trusts were soon opting to exploit their new "freedom" to alter staff pay and conditions..

Ambulance Trust bosses lost no time in seeking to cut back on jobs, pay and conditions, with a 33% pay cut for non-emergency ambulance staff in Lincolnshire, and hefty cuts for emergency and non emergency staff in Northumbria – along

with a "single union agreement" with the scab union APAP with just 40 members among 670 staff.

Almost every trust opted to discard the Whitley Council procedures that gave disciplined staff a right of appeal to the health authority.

As the new market opened up, in Autumn 1991 a confidential report to the NHS Management Executive from Keele University Professor Roger Dyson suggested turning staff into self-employed freelances – with no sick pay, holiday pay, premium rates for overtime or unsocial hours and no pension rights.

The savings to trusts would be so enormous Dyson suggested trusts could offer much higher hourly rates and voluntary redundancy payments or lump sums to lure staff into going self-employed.

If this was seen as outlandish by most Trusts, it was later the basis of plans in Enfield (slapped down by the Department of Health), and in South East Staffordshire Community Trust (who also hoped to privatise portering, catering, laundry, transport services and even chiropody services).

Many Trusts did take up another Dyson idea, putting an ever-increasing proportion of their nursing and professional staff on short-term contracts, making it easier to shed jobs when cash pressures began to bite. And there was and continuing interest in Dyson's call for a dilution of the "skill mix" in key departments, replacing more highly qualified nursing and other staff with (cheaper) staff on lower grades. Many second and third wave Trust applications drew attention to their on-going "skill mix review" as a way in which costs would be reduced.

Chiselling health bosses were also still seeking savings by contracting out non-clinical services: in 1991 West Berkshire put all of its support services including admin and clerical work out to tender, a model followed by Essex Rivers Trust. The rumble of tendering, often with significant job losses, continued into 1992, in Worthing, Barnet, St Mary's (Paddington), and Redbridge.

In London, Parkside Community Trust management, copying the Royal Free Hospital, attempted to cut redundancy costs by "reckoning" that all trust employees had only started on April 1 1992.

There were welcome signs of a fightback by contracted out staff, with successful strikes over pay at London's Maudsley Hospital at Cardiff's Ely Hospital.

However trusts' bureaucratic costs were boosted by an explosion in salaries for top Trust directors, who were very quick to cash in on new "freedoms" to set their own pay scales, while – as many had predicted – the wages of most lower-paid staff continued to rise at less than inflation.

The first £100,000-plus NHS chief executive was Peter Griffiths at Guy's Hospital Trust, where his package reportedly also involved two cars – one for him and one for his wife!

But inflation of management pay was not restricted to Trusts: in Waltham Forest the Community Health Council complained bitterly at a top-heavy management structure in which the local Health Authority had a chief executive and eight directors, as well as no less than 24 "Associate Directors."

Rise of consultancy

The grimly familiar spectacle of costly but unworkable plans being drawn up by management consultants was already in evidence in 1990, with £200,000 (£1,000 per page) squandered on a Price Waterhouse plan that collapsed almost at once, proposing a new 900-bed £140m hospital to replace 1,300 beds at West Middlesex and Ashford hospitals. Price Waterhouse were even brought in to run the finance department at Guy's after its director resigned..

Deloitte produced a plan to separate out the patient transport services from London Ambulance Service and put them out to tender, since unlike the emergency service there was a greater tolerance of failure and "many of the people so transported do not require an ambulance at all." Deloitte were also busily urging the Blood Transfusion Service to become "more business-like in its approach, particularly in the light of an increasingly commercial NHS market."

But one consultancy that could not survive the commercial market was Qa Business Services, formed from a buy-out of computer staff from West Midlands Regional Health Authority, which collapsed in the autumn of 1991 with debts unpaid and contracts unfulfilled

The King's Fund was urging a Californian-inspired reorganisation involving a massive programme of mergers to reduce 190 health districts to just 50 mega-districts – to allow management to "buy in" services more efficiently. Sound familiar?

Competition within the NHS

Within six months of the internal market the chaos was growing.

Orthopaedic patients from Exeter were jumping the queues of local patients waiting for operations in west London.

Consultants at St Mary's hospital were having to wait 4 days for authorisation from clerical staff before offering waiting list patients the treatment they needed – to ensure their health authority would pay the bill.

Bloomsbury and Islington health authority was complaining

continued on page 14...

...continued from page 13

at unpaid invoices for elective treatment for patients from other districts.

The specialist child heart surgery unit at Guy's Hospital exhausted its 1991-92 contract budget for local patients with six months of the financial year still to go.

And the University Funding Council called for government intervention to prevent contracts in the new market going automatically to the cheapest hospitals – which threatened to put the teaching hospitals out of business.

Nonetheless in January 1992 NHS Chief Executive Duncan Nichol claimed that "both patients and staff are feeling the benefits" of the reforms. His offering was castigated by the Health Service Journal and there was a flurry of debate over such a prominent civil servant embracing the political line of one party.

Cold Feet

Waldegrave, heralding the brave new world, began with bravado, declaring in April 1991 that: "It is essential that we let the internal market indicate what is needed in London, and we will then have to respond to those signals, which will force us politicians to take some decisions which have been postponed for much too long.".

But ministers were already getting cold feet on the possible impact of the new market system, especially in destabilising services in the run-up to the coming general election: the market itself was to be heavily controlled, with instructions to health authorities to maintain a "steady state".

Civil servants had predicted that the new capitation-based funding formula in reforms would lead to the closure of another 2,000 acute beds and the loss of at least one teaching hospital in London, and that health authorities in the home counties would seeking to save money by switching contracts for routine treatment to cheaper hospitals outside the capital.

Additional cash suddenly became available – to increase numbers of NHS managers and admin staff to implement the extra bureaucracy in the reforms, and to avert any fresh cuts crisis in the run-up to the election.

With 82% of hospitals facing financial problems, many because they were treating more patients than expected – but not being paid extra because they had agreed to fixed price contracts, an extra £200 million was being pumped in to the NHS behind the scenes to prop up hospitals facing deficits.

Out of control

As the "steady state" wound up from 1993, the fight for contract income was uncovered when leaked documents showed a bitter conflict between acute Trusts in East Anglia. .

In London, Charing Cross Hospital bosses were exposed plotting to destabilise a competitor in the specialist cancer market. A leaked letter declared that "poaching" a top consultant from the Royal Marsden Hospital three miles away "would have the additional benefit of weakening one of our strongest competitors".

Financial pressures forced more closures of acute hospital beds, with the effects masked by a succession of mild winters and the use of "waiting list initiative" funding to reduce the numbers of patients waiting over a year for treatment.

But the sharp winter of 1995/96 triggered a "trolleys crisis" in London and other big cities, and Hillingdon Hospital, struggling to cope with many of its beds "blocked" by elderly patients, hit the headlines when it announced it could admit no more patients aged over 75 until social services found nursing home places for some of those who should be discharged.

The first six years

As the May 1997 election drew closer, the disruptive consequences of the 1990 Act were increasingly exposed, even though some of the wilder plans and projects had been rejected – or swiftly reined in by cautious ministers and more thoughtful NHS management who recognised the need to recruit and retain sufficient staff to maintain services. ther six mental health hospitals by 2024/25.

Many of trusts had been launched on false claims of financial viability and lurched on in near-permanent cash crisis. Private bed numbers had been hugely expanded, but the hoped-for bonanza of private cash had not materialised and many were run at a loss.

Contracting out had continued to erode the standard of non-clinical services. But there had been an extension of privatisation into long term care of older patients, and into mental health. The increased privatisation of long term care as a result of the Community Care reforms had brought bitter localised disputes over "eligibility" for NHS – and the means tested charges for social service – care.

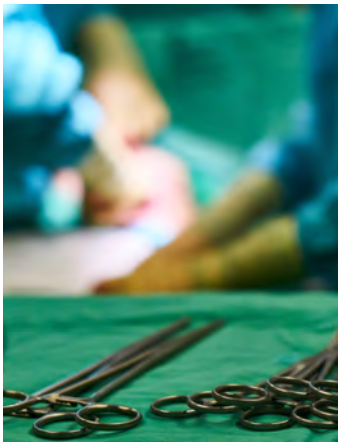
Mental health services too had become increasingly dependent on private provision of medium secure and acute beds as the big old NHS hospitals were run down and closed without adequate alternatives in place.

Strangely almost none of these issues figured strongly in New Labour's electoral challenge – but voters were sick of the sleaze-ridden Tories, and Tony Blair romped home with a 97-seat majority … and a promise to "rescue PFI."

More on that in Part 4...

John Lister

By mid-January 2021, the UK government had awarded £21.6bn worth of contracts related to the coronavirus crisis to private companies.

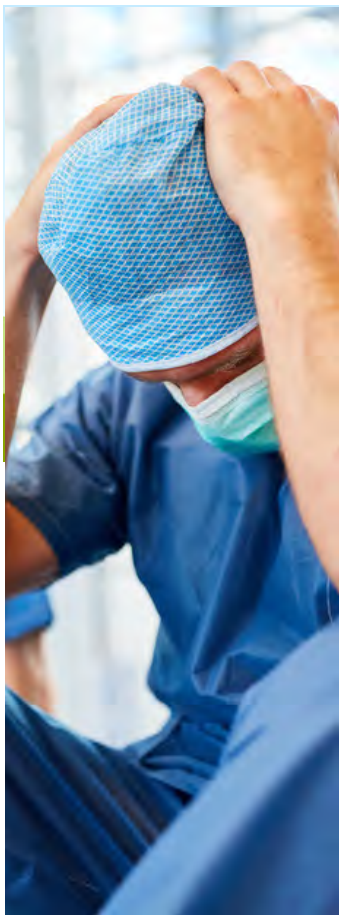


One-third of NHS hip operations, a quarter of cataract operations are performed in private hospitals, and around 6% of NHS surgery overall – although this is expected to rise once the new four-year NHS deal with private hospitals is signed.

76 per cent of the public want to see the NHS "reinstated as a fully-public service" against just **15 per cent** who wanted to see continued involvement of private companies.

The NHS has **12,000** intensive care beds for the sickest patients and in case of emergencies but, according to Laing and Buisson, private hospitals have only **102** ITU beds. There are approx 2,500 emergency transfers from private hospitals to the NHS annually.

Before the pandemic the biggest contract to a single provider was for **£1.06bn** awarded to Sirona, a community interest company for adult community health services in the Bristol, N Somerset and South Gloucestershire area.



In **mental health** care, the NHS often outsources the care of NHS patients – 30% of hospitals are privately run and **44% of health funding** for the care of children goes to private companies – up 27% in five years.

Locally commissioners spend around **15%** on average with the largest spenders allocating up to **26%** – *source CCG accounts for 2019/20* National official figures state that 11% of the NHS budget goes to non- NHS providers, but this is disputed as an underestimate.

The NHS urgently needs significant new investment in its workforce – it has half the EU average in graduating nurses, which undermined the covid response – the expansion in outsourcing has coincided with NHS underfunding.

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