The lowdown

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

Emergency Care Plan raises more questions

A new plan to rescue struggling NHS emergency services, pledging 800 ambulances, 5000 more hospital beds and bolstering community care has been launched by Rishi Sunak. Although the plan is to be supported by a £1bn fund, it has since been confirmed that this is not new funding, which has led to renewed calls for wider action on the staffing crisis and long term investment.

Follow-up analysis of one of the key parts of the plan – to raise NHS hospital bed capacity from its current level of 102,000 has clarified that it will only introduce 1000 new beds as the remaining 4000 represent existing beds which will be moved from other areas, such as top-up bays and corridors.

In fact hospital bed numbers have been falling for a decade, down by 12% since 2011, contributing to the recurrent blockages and delays in accident and emergency. Even

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if the new plan were to open 5000 new beds it would still only return the NHS to the number of available beds in 2010/11 (107,448).

Any new ambition to raise capacity has to first deal with how services will be staffed. and as Patricia Marquis, the Royal College of Nursing's director for England points out "extra beds are only safe when there are enough nurses for the patients in them. And because of the workforce crisis, existing services are unsafe."

Unconvincing proposals

Without the workforce strategy – promised at least two Tory leaders ago, this plan lacks the power to raise capacity and make meaningful change. Professor Alison Leary, nurse and professor of healthcare and workforce modelling at London South Bank University told the Nursing Times "It is hard to see how any meaningful recovery plan can be designed or implemented without the largest safety critical workforce in healthcare."

Important promises to introduce new resources, like the fleet of 800 ambulances which "are expected to be available during 2023/24", sound hollow without a convincing plan as to how they will be staffed within the time frame.

Sunak's attempt at headline grabbing proposals only partially recognises how stresses are passed between sectors. Ambulance workers are amongst those calling for capacity planning across all areas of the NHS as much of their workload results from the excessive pressure on GPs, mental health services and in social care.

The emergency care plan does make a significant promise to expand intermediate care – a care stopover between hospital and home, but this would rely heavily on substantial investment and a strategy setting out who would build and run these new services. Would they be in residential care, private facilities or in new facilities run by the NHS? This is an important medium to long-term ambition but so far there is little detail behind it.

Social care issues unresolved

GPs only receive a cursory mention – with the plan promising alignment with a forthcoming practice access recovery plan, but social care features strongly with commitments to improve collaboration between agencies and discharge procedures.

The report reminds us of the £7.5bn allocated to social care over the next two years, but the major supply side questions remain unanswered. How is the workforce crisis in social care being addressed? Where will much needed extra capacity come from? Age UK point to 2.6 million people aged 50+ who still aren't receiving the care and support they need.

As an unresolved issue social care will be influential in the next election campaign.

Labour have so far not given any further detail on their major policy idea of a national care service since Wes Streeting told the Guardian in the summer "I would love to see a national care service delivered exactly on the same terms as the NHS, publicly owned, publicly funded, free at the point of use, but we've got to be honest about the scale of the challenge. So our starting point is to make sure we deliver national standards for care users and better pay and conditions for staff who work in social care,"

Little focus on capacity

Overall the Emergency Care Plan attempts short term responses but is cornered by the neglectful decisions of previous governments stretching back over a decade. Unsurprisingly there is no mention of the ongoing pay dispute, which is a short term lever the government can pull. Much of the plan focuses on the medium and long term, but too frequently without the detail and funding commitments to persuade NHS staff of a meaningful shift in policy towards building NHS capacity.

The plan unwittingly reminds us that raising capacity across the NHS has been ignored for too long. In the ambulance service the number of calls has increased by 77% between 2011 and 2021 whereas the number of ambulance workers has risen by just 7% – according to a GMB analysis. Ambulance services have "historically been under-funded, with financial settlements not keeping up with ever-increasing demand faced by the sector.

Workforce crisis must be fixed

This has an inevitable negative impact on patient experience and clinical outcomes, as well as the mental health and wellbeing of ambulance service staff." according to NHS providers. Today 80% of ambulance staff say that there are enough staff in their organisation for them to do their job, and despite attempts to recruit and retrain staff many are now leaving the NHS.

Unison head of health Sara Gorton said: "The government has at last acknowledged that there are deep problems in emergency care. But if the prime minister wants to take credit for fixing emergency care next winter, he must first resolve the workforce crisis happening now."

‘Going private’ is not a workforce strategy

With no long-term NHS workforce strategy on the horizon, the government’s default policy on slashing elective waiting lists – pushing more NHS patients towards private hospitals dependent on NHS-trained staff and with only 8,000 beds – seems driven by nothing more than political dogma. How else to explain the 133,000 vacancies, with at least 12,000 hospital doctor and 50,000 nursing and midwife posts left unfilled, that remain across the health service?

Rishi Sunak’s ‘elective recovery taskforce’ project, launched two months ago with the aid of Circle Health and the Independent Healthcare Provider Network, fails to address the lack of a workforce strategy, and is likely to end up just augmenting the four-year £10bn elective surgery deal with the NHS that the private sector already enjoys.

Last year the BMA concluded that this earlier recovery plan was set to significantly increase the outsourcing of services to private providers, in the process threatening “the clinical and financial viability and sustainability of the NHS”.

NHS procedures being carried out by the independent sector is, of course, nothing new. Before the pandemic, commercial operators were already responsible for a third of all state-funded hip operations and a quarter of knee replacements, as well as more than 20 per cent of gastroenterology, trauma and orthopedic NHS treatments – and soaked up more than 20 per cent of CCGs’ budgets in the process. Pressure group We Own It more recently estimated that NHS trusts’ spend on independents rose by 659 per cent between 2012 and 2021.

And Labour, despite last September’s launch of the party’s ten-year plan for the NHS, continues to bear some responsibility for the independents’ ascendant position within the health service. As the Health Foundation wryly noted last year, ISPs (independent sector healthcare providers) have been delivering NHS-funded elective care at ‘independent sector treatment centres’ and private hospitals since the early years of the Blair administration.

That perhaps goes some way to explaining shadow health and social care secretary Wes Streeting’s revelation on LBC back in December, when he told listeners that he would be prepared “to use the private sector to bring down NHS waiting lists faster”.

But nevertheless, Labour’s ten-year plan does actually address the workforce issue head-on, offering a commitment to raising the numbers of district nurses and health visitors, as well as nursing and midwifery clinical placements. As part of this strategy – to be paid for by reintroducing the 45p additional rate of income tax for those earning more than £150,000pa – the party is also promising to double the number of medical places each year.

For the moment however – at least until the general election next May – waiting lists will continue to grow and the independents will continue to make money, effectively creating a two-tier healthcare system to the detriment of the less well-off.

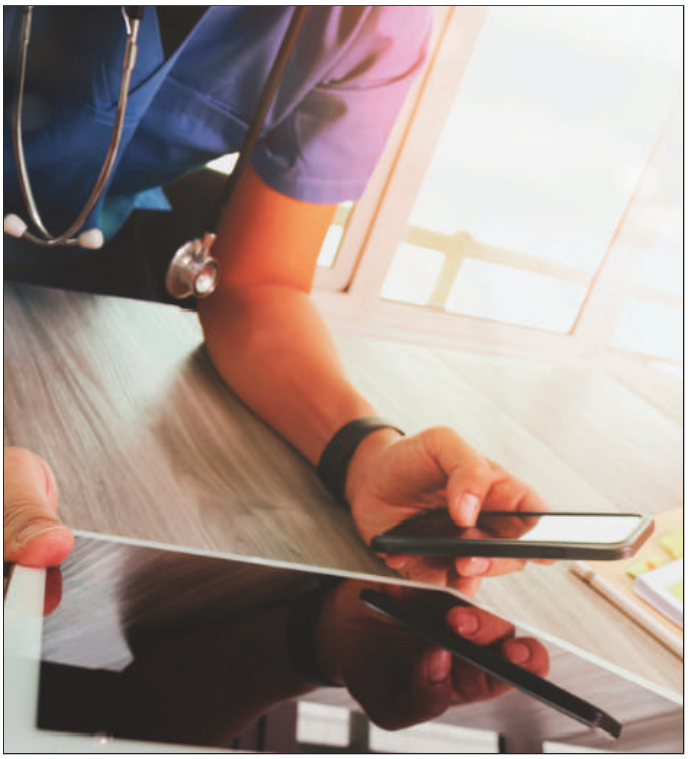
Just consider the following: Lib Dem MP Tim Farron told the Commons last week of one dental practice in Grange-over-Sands that had stopped offering NHS healthcare to its 5,800 patients, effectively depriving them of funded treatment because there are now no NHS dental places available anywhere in the whole of Cumbria. No surprise then that, in the same week, Nuffield Trust chief executive Nigel Edwards told the Financial Times that around 50 per cent of dentistry, by value, is now carried out in the private sector.

And earlier in January, the Observer discovered that several trusts with record waiting lists were promoting “quick and easy” private healthcare services at their hospital premises, offering patients the chance to jump 12-month-long queues

Maybe it’s facts like these that led the former Labour PM Gordon Brown to warn last month that the Tories “seem to find more joy in one person joining Bupa than 60 million people using the NHS”.

Martin Shelley

Patient anger as popular local GP loses out in contract award to company



The decision by Lancashire and South Cumbria Integrated Care Board (ICB) to award a contract to run a well-loved and successful GP practice in Chorley, Lancashire, to SSP Health, a large private primary care company, has been met with anger by patients and staff of the surgery, who have accused the ICB of not running a proper public consultation.

The whole process of choosing a new contract holder by Lancashire and South Cumbria ICB for Withnell Health Centre (WHC) was also conducted with virtually zero input from the public despite the ICB's constitution proudly boasting that it will "put the voices of people and communities at the centre of decision-making and governance."

The ICB has now apologised to patients and staff at WHC over the lack of information around a procurement process for the surgery contract and acknowledged that "more could have been done" to keep them [the patients and staff] informed about the process. It told the local paper the Lancashire Post:

"Further engagement could have made patients and staff more aware of the procurement process and that it could result in a different organisation taking over the running of the GP practice and due to this we would like to apologise."

The campaign for the ICB to revisit the procurement process led by local councillors, GPs and local people continues, however.

The procurement process was triggered in December 2021, when a partnership between Dr Ann Robinson and Dr Mahtab Siddiqui ended. Dr Robinson was awarded a temporary 12 month contract by the then Chorley and South Ribble Clinical Commissioning Group (CCG), but the change triggered a competitive bidding process for the contract for providing care at the practice. The CCG has since been replaced by the regional Lancashire and South Cumbria ICB, who continued the process.

Inadequate consultation

The only information received by the patients about the process was a single letter sent out in February 2022, saying the CCG has awarded a temporary contract to Dr Robinson for 12 months as "the least disruptive option for all parties" and there should be "very little to no impact on patients as a result of this change."

The letter also reassured patients that they "should not be concerned about the future of the practice" and "the 12-month period will now be used to undertake all of the necessary due diligence steps required before a longer-term contract can be awarded."

A patient survey was attached that could be filled in and patients were told that "any feedback you have about the practice and services you receive will feed into the wider analysis as part of the due diligence process."

What the letter failed to outline is exactly what the process of awarding a new contract entailed and that it could lead to the loss of Dr Ann Robinson, who has been the principal partner at WHC for 10 years. As far as the campaigners are concerned, the letter and patient survey does not constitute a public consultation and the ICB's apology indicates that it also now realises that this was not sufficient.

Even when a decision had been made in December 2022, only Dr Robinson was informed and given a ten day window to submit an appeal. Dr Robinson was told not to talk about the decision – a gagging order – until the end of the 'standstill' process 30 days later.

Patients only found out about the awarding of the contract to

SSP Health and therefore the loss of Dr Robinson as the contract holder when it was leaked on Facebook by a member of staff at WCH in January 2023.

The news was met with dismay and anger by patients and staff, and now over 1,500 of the patients registered at WHC have lodged written objections to the ICB decision to take away control of the GP practice from Dr Ann Robinson. Monday 16th January saw the lifting of the gagging order on the staff at the surgery and on the 17th the staff of WHC gathered at the ICB headquarters to protest. Here they found that the envelope containing the 1,500 objections had not been opened and was still sitting at reception.

The ICB has since stated that the objections are now being "read and processed", but what effect they could have on the completed process is unclear.

Roots in the community

Several of the staff at the Withnell practice have said that they would rather resign than see the surgery handed over to SSP Health.

Dr Robinson, patients, staff and local councillors are angry that a surgery that scores highly on patient satisfaction and has such deep roots in the local community could lose its contract to a company they say whose GP surgeries score far worse on many measures including patient satisfaction. Dr Robinson told the Lancashire Post that:

"The current care that they [patients] get is absolutely wonderful and there is data to back that up. We have same-day appointments, a fantastic nursing team and the lowest A&E attendances across the whole of Chorley and Preston…My practice doesn't have a problem recruiting either, because it looks after its staff and it pays them well."

Margaret France, a retired GP and now a local Labour councillor and Chorley Council's lead member on shared services, joint working and community wellbeing, who left the surgery in 2013 and passed it on to Dr. Robinson has also highlighted the high performance scores the Withnell surgery has in comparison to SSP:

"If you look at the percentage of patients who find it easy to get through to their GP practice by phone, you've got a national [average] result of 53 percent. Withnell Health Centre is at 82 percent and if I look along the line for SSP, there are an awful lot of red numbers [indicating scores below the national average] and the lowest is 16 percent".

Across the 18 performance criteria listed, Withnell Health Centre is above the national average – sometimes significantly so – in 17 of them and equal to it in one.

Opposition also comes from GP surgeries in the surrounding area. Local GP surgeries and WCH are part of 'Chorley Together' a primary care network (PCN), that involves a collaborative arrangement to enable GPs to offer a wider range of services and more easily manage their affairs and recruit and retain staff.

Chorley Together's business manager has written to the ICB board to express its members' "dismay and concern" at what they describe as a "fundamentally flawed" procurement process concerning WCH.

The business manager, Claire Hounslea, also noted that the PCN would not be welcoming SSP Health to the network as:

"The values and behaviours of SSP do not align with [those] of Chorley Together PCN and its member practices… [the board] will not accept SSP into the PCN if they remain the ICB's preferred bidder for Withnell Health Centre. We will not be intimidated or bow to pressure from the ICB to do so."

As part of the campaign, Cllr France has met with Chorley MP Sir Lindsay Hoyle and shown him patient objections to the takeover. Sir Lindsay has "made contact with the Integrated Care Board to ask for this decision to be reviewed and for all concerns raised by local residents to be addressed before any further action is taken."

Cllr France believes that the tendering process did not involve a public consultation process.

"It seems inherently unfair to me that the health centre can be passed over to an outside conglomerate without any public consultation whatsoever." said Cllr France.

Supermarket service

SSP Health managing director Amanda Carey McDermott last week insisted that its aim for the practice was to "retain the team, continue their good work and add to the services available to patients".

She added that "As with all GP surgeries, Withnell Health Centre has always been privately owned, run with the local community as its primary focus, and this is something we do not want to change."

Although it is true that WHC is privately run, as all GP surgeries are, there are major differences between a GP surgery where the resident GP or GPs have a single contract and a company that holds contracts for 40 GP surgeries.

Dr. Robinson told the local press that the interests of her patients will not be served by what she describes as "supermarket GPs".

"These big practices cut services to the bone. I know for a fact that SSP took home £4m in profit last year, which is taxpayers' money which should be spent on improving your access to GPs."

SSP Health is wholly owned by the private company SSP Health Holding Ltd, which according to Companies House, has a single director and shareholder Dr Shikha Pitalia.

The company's turnover in the financial year to end of March 2021 was £9.3 million, which led to £3.6 mn in profit and in the 2021/22 financial year turnover was £11.1 million and the profit was £2.3 million.

Sylvia Davidson

Problems mount for New Hospitals Programme

Concerns over the New Hospitals Programme (NHP) have been growing in recent months, since NHS Providers warned that it was on "shaky ground" last July, since half of the trusts in the programme were not confident that they had been allocated sufficient funding to deliver their project.

In October the fears were reinforced by a report to the NHS England Board that again warned that "The Programme has not, to date, had a budget for the full Programme agreed by HMG, a Programme scope or timeline."

NHS England has also been keen to emphasise that they are not responsible for the delays and the problems: "It is also currently a DHSC Programme, although it is supported by NHSE

staff," a point echoed again at the December Board meeting.

The report went on to reiterate that not only are many of the schemes much less than a new hospital, but the 40 projects incorporate seven schemes that were already in progress before the promised building programme was announced (as discussed above): "The New Hospital Programme has now met some major milestones; the first of the full 40 hospitals – the Northern Centre for Cancer Care – has been completed, and six further hospitals are under construction.

Shambolic state of play

A table at the end of the report showed a shambolic mixed state of play, with the one project completed, six 'under construction', one (a new eye hospital for Moorfields) awaiting approval of a Full Business Case, 18 yet to agree an Outline Business Case, 10 still to complete even a Strategic Outline Case, 3 still further behind, developing a Pre Consultation Business Case, and one ("Full refurbishment of Charing Cross Hospital and a mix of refurbishment and new rebuild at Hammersmith Hospital") noted as "TBD" – presumably To Be Decided.

Nor did it give any indication on when decisions will be made over the additional eight projects that would make up the total to 48. The report states:

"Linked to the upcoming review of the programme business case, decisions are under review with HMT and No.10 to take forward the inclusion of the next eight schemes in the programme. Additionally, we continue to work with DHSC and HMG to secure a solution for the hospitals impacted by reinforced autoclaved aerated concrete (RAAC), which will need new builds to properly mitigate their risk of closure over the next 10 years."

A few weeks later, following Jeremy Hunt's Autumn Statement, the LibDems revealed that the combination of allocations and projected rates of inflation amounted to a £700m cut to NHS capital funding, and warned this would make it even less likely any new hospitals would be built.

In mid December NHP told an industry event hosted by the DHSC that all new hospitals are to be built with single rooms only. They did not admit that is likely to require amendments to many trusts' current proposals, creating further delays and increasing costs. Providers expressed anxiety about costs and funding, while Nuffield Trust chief executive Nigel Edwards told Medscape News UK:

"There is some evidence that single rooms can reduce infection rates, although they can also cause issues with patients feeling isolated. They may also increase the need for nurse staffing and observation to prevent falls."

By January 1 even the ardently pro-Tory Daily Telegraph was warning that only seven of the promised 40 hospitals even begun construction – while remaining tactfully silent on the fact that all seven had been in progress before the promise was made.

Two weeks ago one of the first hospitals promised funding for a rebuild, the 414-bed Princess Alexandra Hospital in Harlow, revealed the project, a new £850m hospital on a greenfield site, was held up awaiting the green light on funding. Initial hopes on having the new hospital running by 2025 have given way to fears that unless a decision is made soon it may well not be opening until 2028-2030.

Lack of planning permission

When asked to comment the Department of Health once more repeated the initial promise of £3.7bn for the "biggest hospital-building programme in a generation": but if replacing a 414-bed hospital is to cost £850m, it's obvious that the funding is nowhere near enough to build even five new hospitals.

Now, as this Lowdown article is completed, the Observer has homed in on more evidence that the NHP is in disarray, warning that only ten of the promised 40 new hospital projects have the full planning permissions they need to go ahead.

Combining the Observer's own analysis with official data obtained by the Lib Dem deputy leader, Daisy Cooper, the article finds some projects "only have outline planning permission, which is insufficient to allow building work to commence," while many of them have no planning permission at all.

One obvious reason for this is that without a business case for a new hospital or any idea of how much money is on the table to build it, NHS trusts can't put any clear proposals to planning committees.

The same article also tacitly raises another issue of concern: whether the new hospitals will contain sufficient capacity to meet the growing needs of their local population. It quotes Health Foundation estimates last year that the NHS would need 23,000-39,000 new beds in England by 2030, "equivalent to around 38–64 average sized hospitals."

Cutting, not expanding

But of course most of the new hospitals would not be offering extra beds, but replacing existing clapped-out buildings. Concerns have been raised over the reduced bed numbers in the proposed new Whipps Cross Hospital, and the belated opening of the Royal Liverpool Hospital last year brought immediate complaints that bed numbers had been reduced from the previous hospital.

Couple this with the ongoing questions about the level of capital available, pressures on trusts to reduce the size and costs of their schemes, and the continued high rate of inflation, and we can see real grounds to fear that even the hospitals that are built could be far too small and bogged down in immediate crisis.-

John Lister

Leamington 'megalab' faces closure

The Rosalind Franklin Laboratory in Leamington Spa, which opened in the summer of 2021 at a cost of up to £1billion and was the largest of its kind in the country processing Covid 19 tests is now set to to close, with all but 50 of its 700 agency staff given 4 weeks notice.

Back in the summer of 2021 The Lowdown reported on the delays in opening the "mega lab" in the old Wolsley buildings in Leamington Spa, which was supposed to employ 600-plus people and take on the processing of millions of Covid tests, as part of the £37bn "test and trace" system chaired by Tory crony Dido Harding.

Harding had let slip to unions on the NHS Social Partnership Forum that a private company, Medacs, was to be given the contract to run the new labs, although like so many PPE contracts, the contract had not been advertised or put out to tender.

Medacs is a subsidiary of the multinational Impellam Group, chaired by former Conservative Party deputy chair and tax exile Lord Ashcroft.

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

The Leamington Courier reported an anonymous worker in the lab who warned that the lab and its staff would be left outside the NHS, and that people on universal credit were being recruited to a specific "trainee lab technician" role.

In June 2021 local MP Matt Western warned that:

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

At its peak the lab was processing at the rate of 8.5 million tests per year. But now a statement from the UKHSA says it can scale up PCR testing quickly if required – for example, if a new concerning variant meant increased PCR testing was necessary or in the event of a future pandemic.

"Now that the number of PCR tests has reduced significantly, processing can be undertaken by existing NHS laboratories."

Western, whose office helped the Independent investigation that revealed that the cost of the lab was up to double the initial projection of £588m, has now told the BBC he wants answers about the running of the lab:

"At the time it was not clear whether this way going to be an NHS facility or a private facility," he said. Questions need to be asked about where those agency workers came from, who made money from that."

And of course who stands to gain if another pandemic comes along and requires this or another lab to be reopened once again.

John Lister

Early integrated care project wound down after failings

The past few weeks have been a difficult time for the development of the holy grail of health policy - integrated care: an NHS trust in the Midlands that was supposed to hold a 'landmark' integrated care contract worth £360m is set to be wound-down, and a contract in the Wirral heralded as achieving 'truly integrated' health and social care service is to be terminated after six years as it brought no improvements in care.

Alongside these failures, came a briefing from the Nuffield Trust and The Health Foundation that places much of the blame for the failure of integration in health and social care on the lack of change in working cultures in the NHS and social care to support collaboration..

Writing in the HSJ, Helen Buckingham, director of strategy and operations at the Nuffield Trust, and Sarah Reed, improvement fellow at The Health Foundation, note that "Integration has too often felt removed from the day job of those working in services, and from patients and service users who would gain so much from seeing that more joined-up care delivery actually happens."

The Black Country, once considered a leader in developing integrated care, will now see the scrapping of a trust set up to hold a £360m contract for the integration of health and social care across the region, Dudley Integrated Health and Care Trust (DIHC).

DIHC, which began development over eight years ago, is now going to be wound down or merged with another trust by the Black Country Integrated Care Board (ICB).

Hostility between Trusts' staff

Initially the development of DHIC was actively backed by NHS England, which designed a new type of contract for the trust to hold as an Integrated Care Provider (ICP).

However, it was not universally supported across the region, in particular at The Dudley Group Foundation Trust, the local acute trust. In July 2020, senior clinicians at the acute trust wrote a letter to the CCG, both trusts involved, and NHS England, asking that a risk/benefit review of the care model be carried out and the development be paused for 12 months.

A review produced by Mike Richards for NHSE warned of "really poor relationships" and "hostility" within the Dudley system, in particular between leaders and clinicians working at the acute trust and the new NHS trust.

In April 2021 Dudley CCG said it was ready to transfer the final £360m worth of services to the new NHS trust, DHIC, but this never happened as NHSE intervened and stopped the transfer.

DHIC was supposed to hold a single contract for primary care, community health, community mental health, and some public health services. Some services were transferred, but not the community services run by local acute provider Dudley Group Foundation Trust, the largest component of the new contract.

At the moment, DIHC runs only around £20m worth of services, for improving access to psychological therapies and a primary care mental health service, plus some commissioning activities.

In contrast, in the Wirral a contract that integrated health and social care at a single trust has been running for almost six years, but is being axed following a review that found no improvement in the service.

In June 2017, Wirral Council awarded a contract for the major part of its social care services to Wirral Community Health Care Foundation Trust (WCHC). The contract had an annual cost of £10m.

Around 240 staff were transferred from the council to WCHC, including those who commission social care provision and assessment and reablement workers. The trust also had responsibility over the wider social care budget.

WCHC has stated it has made Wirral one of the few places in the country to have made "significant progress towards truly integrated health and care provision". However, despite the integration a recent review of the contract by the council concluded: "Whilst services have remained safe and of a good quality the review has not evidenced significant and sustained improvement of service outcomes for people through delivering under the current delegated arrangements."

As a result of the review and other considerations surrounding cross-working within the council, the council has decided to bring the social care services back in house.

Now, however, the exact timing of the contract ending has become uncertain for everyone involved, including the over 200 staff involved. The council has suggested an extension to September 2024, but WCHC has told the council that they had concerns regarding the one year extension and they want a longer contract or it would be transferred back to the Council by 1 April 2023.

The two organisations are reported to be now in discussions about agreeing a compromise, which could be for the contract to run until the current end date of September 2023.

Private gravy train hits the buffers?

The massive 25% leap in NHS spending on private providers in 2020-21 appears to have been followed by a 10% reduction according to the most recent Department of Health and Social Care Annual Report.

A year ago the previous DHSC report showed spending on "independent sector providers" increased from £9.7bn in 2019/20 to £12.1bn in 2020/21 (up 25.6%). A major factor in this was the massive contract signed in 2020 for a big increase in numbers of NHS patients to be treated in private hospitals, although as we subsequently discovered relatively little of this capacity was actually used.

And while further "framework contracts" with private hospitals appeared to indicate that this higher level of spending was likely to continue for some time, the latest figures suggest that NHS trusts and commissioners have pulled back as much work as they can, rather than see precious NHS funds flow out to private providers.

In terms of elective work, the government's strategy still rests heavily on the use of private hospitals to tackle waiting lists, but their limited bed capacity and the competing demand from private patients leaves little room for NHS patients, which may be another factor in these figures.

2021/22 saw spending on private providers fall back from the £12.1bn peak to £10.9bn, and spending on private sector fall as a share of total spending, from 7% to 6%.

There is of course a long-running debate about how accurate these figures in the DHSC annual reports may be on the real level of spending on private sector contracts: some analysts argue the private sector share could be three of four times higher, depending on how we define for example GPs and primary care services.

Expenditure stalling

But what is clear from the latest report is that while NHS spending on services from local authorities has remained at the higher level seen in 2020/21, spending on private providers has not continued the rapid upward trajectory indicated a year ago, and spending on non-profit and voluntary sector, which increased by over 9% in 2020/21 has now fallen by 4%.

Perhaps the most significant fall, given the current concerns over the impact on the NHS of large waiting lists and long delays, has been in NHS income from private patients, which was down to £540m in 2021/22, a 20% drop from the pre-pandemic level of £671m in 2019/20.

Research from the Centre for Health and the Public Interest (CHPI) showed last year that the five largest NHS providers of private treatment (The Royal Marsden, Great Ormond Street, Imperial, Royal Brompton, Moorfields Eye Hospital – all in London) generated a total of £327m in 2019/20 – 49% of the total. This suggests that in much of the country little or no income was generated by NHS private patient units: CHPI questions how many may be actually running at a loss.

CHPI note that in 2016 1,143 NHS hospital beds were set aside for private patients – equivalent to 1.1% of England's 103,000 general and acute beds. But the recent figures show private patient income well below 1% of the NHS England £151bn budget (0.35%).

While the income is reported, the running costs (and thus profit margins) of the private patient units are a closely-guarded secret, especially for the Big Five: CHPI lost an appeal to the Information Tribunal for the Royal Marsden trust to be obliged to publish its profit margins.

Unless it can be proved otherwise it seems safe to assume that the majority of NHS Private Patient Units run at a loss, or make only the most marginal contribution to the income of the parent trust, while diverting precious staff from their wider duties..

John Lister

High prices explain static numbers paying to go private

It's no surprise to find the Daily Telegraph singing the praises of private medicine, but readers encouraged to take up the apparent bargain basement prices quoted in a January 25 article entitled 'The five health treatments you should go private for' are in for a rude awakening.

Top of the list is 'hip and knee replacements:' but while the NHS waiting times are indeed agonisingly long, it could take even longer to locate any private hospital in Britain willing to do a knee replacement for the Torygraph estimate of £950 to £2,500. The real figure is almost six times higher.

The Practice Plus group website, for example, explains that "as a guide price, you can expect to pay anything from £5,000-£15,000 for your knee surgery, while Private Healthcare UK puts the average cost of partial knee replacement at £11,106."

Costs of hernia repair are equally drastically underestimated by the Telegraph at between £300-£800, while the Best of Health website warns the typical cost is more than five times higher, between £2,390 & £4,406 (excluding initial consultation and prior diagnostic tests fees).

On cataract surgery, the Telegraph estimates costs between £838 and £2,445 excluding consultant fees, while the Laser Eye Surgery hub states that prices per eye are between £1,995 – £3,150 for standard monofocal lenses and £3,495-£4,100 for multifocal lenses.

The Torygraph hack, Abigail Buchanan, appears to have based her figures on a new, misleading calculator promoted by the Private Healthcare Information Network (PHIN).

It's not clear how this outfit, which solely exists to drum up trade for private hospitals, could have got the figures so wildly wrong: but perhaps they are desperate to see some uplift in the stubbornly static numbers of people seeking private hospital care.

Back in December the PHIN published figures for the second quarter of 2022/23 which showed only the most marginal increase in numbers of private operations since 2019, despite the massive increase in numbers stuck on NHS waiting lists.

Right wing newspapers (and some confused left wing campaigners) seized upon the 33% increase in numbers of "self-pay" patients being treated in Britain's mostly tiny private hospitals: but they have ignored two other important facts.

One was that the 33% increase was from a very low base, so in fact only added 17,000 extra patients to just 50,000 self-pay punters in the same period in 2019. The other was that there has been a corresponding drop in numbers of insured patients – leaving the total almost unchanged.

It's also worth noting that almost half (47%) of the self-pay patients were in just three regions (London, the South East and South West) where the private hospitals are most concentrated.

The reality seems to be that many people stuck on NHS queues are either waiting for treatment the private sector doesn't offer, or unable to pay the much higher costs of private treatment than the PHIN wants people to know about.

Whatever the reason, the private sector is clearly not booming or expanding that much, and the real statistics underline how vital the NHS is, and what good value it represents, especially for the Torygraph's many older readers.

John Lister

Auditor points to flaws in Department financial controls

The Department of Health and Social Care (DHSC) finally published their annual report and accounts for 2021-22 at the end of January – but were rapped over the knuckles for their content.

Gareth Davies, the Comptroller and Auditor General (C&AG) and head of the National Audit Office (NAO), issued a "qualified audit opinion" on the accounts, not least because of the handling of the affairs of the UK Health Security Agency (UKHSA) which was established as a DHSC agency in April 2021 and became fully operational from October 2021.

The UKSHA was the body set up to replace Public Health England, and now responsible for England-wide public health protection and infectious disease capability. Its Chief Executive is Dame Jenny Harries. From the outset it was "heavily reliant on temporary staff, including in key senior roles, and experienced high levels of staff turnover."

However there was also a lack of clear governance, oversight and control, with no Board or Audit and Risk Assurance Committee in place. Indeed the Advisory Board and Audit and Risk Committee did not meet formally until last summer, and in the view of the C&AG "This lack of formal governance arrangements exposed UKHSA to a high level of risk, with no clear oversight structure in place for its first six months of operation."

Davies criticises the DHSC for not sufficiently supporting or overseeing UKHSA to establish its administrative functions.

But the biggest concerns are once again over the colossal costs and lack of adequate information over the stockpile of unused and unusable PPE and other goods related to the pandemic.

The C&AG's report notes:

"DHSC did not complete an effective programme of year-end stock counts to verify the quantity and quality of items including PPE and lateral flow tests, as it was unable to access 5 billion items (which cost £2.9bn) that were stored in containers, and did not have adequate processes in place for accessible stock held in warehouses."

As ministers endlessly repeat their assertion that a decent pay rise for NHS staff is not affordable, the accounts show DHSC has wasted almost £15 billion over two years on PPE and other pandemic spending:

"DHSC estimates that there has been a £6bn reduction in the value of items procured in response to the pandemic. This comprises: £2.5bn write-down on items costing £11.2bn that DHSC has already purchased, but no longer expects to use, or for which the market price is now lower than the price paid. (This includes £1.5bn of PPE, £5.8bn of Test and Trace consumables such as lateral flow testing kits and PCR tests, £2.7bn of COVID-19 vaccines, and £1.2bn of COVID medicines.)

£3.5bn write-down on PPE, vaccines and medication which DHSC has committed to purchase, but no longer expects to use. "Taken together with the £8.9bn written-down in its 2020-21 accounts, over the last two financial years, DHSC has now reported £14.9bn of write-down costs related to PPE and other items."

Davies calls on the DHSC to set up adequate controls over its remaining COVID-19 inventory, which "should include processes to physically verify the amount and condition of the items held in containers and warehouses.".

John Lister

NHSE turns to contractors to make staff feel valued

NHS England has come up with a bonzer way to make up for the lack of pay and one million-plus staff feeling undervalued: dig up a long-forgotten "People Promise" – and bring in a private consultancy to try to make health workers feel "valued".

Even better, dress up the whole exercise as "training" in which at least half the content consists of staff sharing their own grim experiences of dealing with awkward and frustrated people on the front line.

Tell them they are getting a "trailblazing" on-line course – and prove it by quoting NHS staff saying it's the first time anyone in the NHS has listened to them in 23 years!

NHSE obviously felt unable to develop its own serious initiative on Health and Wellbeing, not least because the tightening budget and the need to generate £12 billion-plus in "savings" by 2025 have meant the few welcome perks that were on offer to staff during the peak of the pandemic – free car parking, hot food for staff on night shifts, responsive support with mental health – have now been axed.

And while nurses, ambulance staff and others have taken to strikes and picket lines, NHSE knows they can't solve the really big problem of the reduced and ever-shrinking real terms value of NHS pay without any move by government to cover the cost.

So they have wheeled in yet another consultancy firm, this time "global workplace-training and digital skills provider" escalla (with trendy lower-case 'e').

They have drawn up the first new online course, one that aims to help staff fend off verbal and physical abuse from angry patients, and to better care for themselves and others "with compassion". All very useful, no doubt – especially when such problems are fuelled by chronic staff shortages, leaving staff barely able to cope with normal levels of demand, let alone the record post-pandemic backlog.

It's a long way from focusing on staff wellbeing, recognition and reward. Nonetheless NHS England's lead on Health and Wellbeing, Claire Parker and escalla's Serena Field have now written an article claiming that by simply developing this first course to help staff cope, NHS England have been able to meet "some of the key commitments made in the NHS People Promise."

The People Promise, now ringing more than a little hollow, as we have pointed out in The Lowdown was produced back in 2021, while many of the special pandemic period wellbeing measures were still in place, before inflation soared into double

figures, and before the latest morale-sapping plunge in NHS performance.

It was NHS England's attempt to substitute for a meaningful pay increase by developing its own on-line corporate waffle.

It promised that – by 2024 – nurses, doctors paramedics and all, should be able to declare that: "We are recognised and rewarded. A simple thank you for our day-to-day work, formal recognition for our dedication, and fair salary for our contribution." We now know that can only be achieved if the strikes succeed in forcing the government back from its confrontational stance.

Equally unlikely is the other main promise that depends on funding, and which flies in the face of the £10billion-plus backlog of NHS maintenance and the desperate shortages of NHS capacity: "Wellbeing is our business and our priority … . We have what we need to deliver the best possible care – from clean safe spaces to rest in, to the right technology."

Oblivious to all this, Claire Parker insists the new course helps staff to feel valued "and feel as though the NHS is investing in them and their skills." And she claims, implausibly, that this "surely goes a long way to supporting some of the recruitment and retention issues…"

But the puffery on this initiative, published to senior NHS managers in the ever-servile National Health Executive magazine, ends with several plugs for escalla and its various other courses, indicating that the only tangible investment has been in fat fees to yet another private consultancy, rather than in the NHS or its own staff..

John Lister

Ontario's lurch to privatisation – a warning to Labour

At the end of last year Shadow Health and Social Care Secretary Wes Streeting decided to wind up Labour supporters and delight Telegraph readers by proposing increased use of the private sector as a key element in reducing the 7.2m NHS waiting lists.

He may well have thought he was echoing the decision by Tony Blair's government to use private hospitals and create "independent sector treatment centres" in the 2000s.

New Labour's obsession back then was to carve out a share of the substantial increase in NHS funding to expand the puny private healthcare sector and create more of a competitive "market." However any decision now to use private providers would mean taking even more money (and staff) from a financially hobbled NHS.

Now in Canada Ontario's hard right provincial government, led by Doug Ford, has controversially opted for an almost identical policy – as part of an agenda to entrench the private sector in the lucrative provision of elective hospital care.

Ontario, like England, has been plagued by chronic underfunding, desperate shortages of beds and staff, and with huge waiting lists for treatment. On January 16 Ford and Ontario Health Minister Sylvia Jones announced plans to respond to this – by "significantly" expanding the number and range of publicly-funded operations performed in privately-run for-profit health facilities outside of hospitals.

The provincial government plans to contract for an extra 14,000 cataract surgeries a year, about 25% of the current wait list, and to invest C$18 million in existing private centres to fund medical imaging and certain surgeries. And new legislation will aim to expand the provision of services and surgeries in private clinics.

This is not what Ford and co told the public in the run-up to provincial elections last June: Ford's "Progressive Conservative Party" toured the province time and again denying any intention to privatise health care.

'Easy' work on offer

Nonetheless, just as campaigners had warned, two months after the votes were counted Sylvia Jones revealed the real plan – to "help stabilise" the province's health-care system by increasing the number of publicly funded operations performed at existing private clinics.

Ford and Jones have now made clear that they regard up to 50% of the work done in Ontario's hospitals as "easy" work that could be handled safely in smaller and less-well resourced facilities – leaving the tougher and costlier cases to the main hospitals.

The latest moves threaten to undermine the universal single-tier, publicly-funded system that so many Canadians have been proud of, and see as distinguishing them from the disastrous system in their powerful neighbour to the south.

In Ontario the Private Hospitals Act banned new private hospitals in 1973: as a result there are currently just three for-profit hospitals in the province.

Federal law (the Canada Health Act, which in 1984 enabled the country to break from the previous American-style insurance-based health care system, and established a tax-funded system of universal social health insurance) largely prevents the private delivery of hospital care. It also bans extra billing for necessary services, a provision which is regularly violated in private clinics.

Because the Canada Health Act is focused on hospital care, in recent years, as public spending has been constrained by provincial governments, there have been increasing efforts by the private sector to get around the letter of the law – by expanding the provision of diagnostics and various elective procedures outside hospitals, in free-standing "clinics" and other facilities.

The latest proposal to make extensive use of these for-profit providers to perform uncomplicated joint replacements and cataract surgery, paid for through the tax-funded Ontario Health Insurance Plan (OHIP) has triggered an angry reaction from health-care professionals, concerned that the move would drain resources from publicly funded hospitals and benefit the owners of private-sector clinics without improving patient care.

Funding moves from public to private

The anger is increased by the fact that underfunding of health care by Ford and previous Ontario provincial governments has left many public hospitals with operating rooms that are closed in the evenings, on weekends, for days and months at a time, or even permanently, due to lack of staff. MRIs and other diagnostic services in public hospitals have also been limited due to inadequate funding and staffing.

Rather than fund the public hospitals properly, the Ford government plans to pay substantially more per operation to private providers. Back in January 2020 a call for "Applications to License Independent Health Facilities for the Provision of Cataract Surgeries in Ontario" made clear that these operations would be paid for at 20% above the going rate in public hospitals.

The College of Physicians and Surgeons of Ontario, the agency that regulates doctors in the province, says it was not informed of the government's latest plans to implement the changes. Spokesperson Dr. Nancy Whitmore argued using private providers is not the solution to the health-care crisis, and warned "It would further tax our health human resources shortages and further increase wait times for more urgent hospital-based care."

Simply dumb

Bob Bell, a former chief executive of the University Health Network in Toronto, and a deputy minister of health in Ontario under the previous Liberal provincial government, has argued in favour of performing certain operations outside of hospitals in purpose-built community surgical facilities, but insists they should be run by non-profit hospitals.

He told CBC News "I totally agree with their desire to do more surgery by moving it out of the hospital into the community. But moving it to a for-profit model is simply dumb."

The danger is that any increase in simple elective activity by for-profit providers simply hoovers up staff from hard-pressed public hospitals, leaving even weaker core provision of services for patients with the most serious and complex needs. Last March an Ontario Hospital Association survey found one in eight full- and part-time permanent positions vacant for registered nurses and more than one in ten for registered practical nurses.

Ford likes to campaign on the slogan "For the People," and

insists that because the treatment would be paid for through the publicly-funded system, it's not really privatisation at all: "I don't even like the word 'private' because it's really not. No Ontarian will ever have to pay with a credit card. They will pay with their OHIP card."

But funnelling of public funds into private sector provision will further undermine public provision, and increasingly open up a market in which those able to pay for treatment seek to jump queues by going private.

Campaigners have been warning of the potential ruinous cost of private treatment with the various additional charges that are likely to be added. In the most recent study done by the Ontario Health Coalition, clinics were caught double-billing, charging patients thousands of dollars and charging the public health system at the same time for the same procedure.

The report showed patients are routinely charged ten times the public health system cost for private for-profit shoulder surgeries, four or five times the cost for private cataract surgeries, and three times or more the cost for private MRIs.

So while campaigners do emphasise the scale and impact of medical debt in the US (and in other provinces of Canada that have gone further and faster than Ontario), the main danger in Ontario is not American health corporations but grasping Canadian capitalists; not the restoration of the US system based on private insurance, but the increasing privatisation of publicly funded elective care. This offers the private providers the easiest profits, while the public hospitals would remain saddled with the emergencies and more serious cases.

The way this is being argued by Ford's right-wing government in Ontario should be a warning sign to Labour to change course: all of the negative consequences of the policy would apply equally here.

The Ontario Health Coalition (OHC), which over the years has had to fight and repel a number of previous attempts to undermine the single-tier publicly funded Medicare system in the province, now warns that once again it faces an existential threat.

Speaking to a well-supported February 1 online rally that drew in a dozen members of the provincial parliament, community organizations, trade union and political leaders and academics, OHC director Natalie Mehra stated the need to build the biggest and broadest-possible movement in defence of Medicare, to stop the Ford government in its tracks.

In an emotional appeal, Natalie made clear her concern that after her 27 years of constant campaigning against the privatisation of health care in the province, defeat this time could have long-lasting and serious consequences.

"Once they [private providers] are in, it will be very difficult to get them out again."

With strong support from major unions, OHC is holding 'town hall' meetings across the huge province in the second half of February, planning resistance when the plans come to the provincial parliament in Toronto, and planning to hold referendums in every area to show the scale of the public opposition "anywhere we can put a ballot box and gather votes" – with a target of getting a million votes from the province's 15 million population..

John Lister

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If you've enjoyed reading this issue of The Lowdown please help support our campaigning journalism to protect healthcare for all.

Our goal is to inform people, hold our politicians to account and help to build change through evidence-based ideas. Everyone should have access to comprehensive healthcare, but our NHS needs support.

You can help us to continue to counter bad policy, battle neglect of the NHS and correct dangerous mis-information. Supporters of the NHS are crucial in sustaining our health service and with your help we will be able to engage more people in securing its future.

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.

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