THE lowdown

Health news, analysis and campaigns.
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Informing, alerting and empowering NHS staff and campaigners

Circle's defeat hailed as a victory by campaigners

A crowd of campaigners rallied outside the High Court's Rolls Building on May 15 to express their support for the decision to end 11 years of privatisation and allocate a major treatment centre contract to Nottingham University Hospitals Trust rather than private hospital firm Circle [as we headlined in our last issue].

Within a week of the hearing the news emerged that the NHS had won, and Circle's case had failed.

The campaigners had responded to calls from Keep our NHS Public in Nottingham, UNISON's NUH branch and Unite activists in Nottingham who had campaigned to get Circle's contract, yielding £2.9m a year of profit, ended.

They has welcomed the decision when it was finally made by a consortium of 16 CCGs in the East Midlands and Yorkshire led by Rushcliffe CCG, and endorsed by NHS England's Regional Director.

But celebrations will be muted until a further threat of legal action by Circle, seeking damages from the CCGs, has been dealt with later this year.

Background: see inside, page 2

Harlow hospital staff announce six days of strikes to stop privatisation

Backed by an overwhelming 99% majority vote of almost 84% of UNISON members voting and by the other unions at the hospital, domestics employed by Princess Alexandra Hospital Trust in Harlow have announced six days of strikes against their service being subjected to market testing.

The strikes will begin with a single day on June 6, the date of the next Trust board meeting, with further strikes if the Trust does not see sense on 11-12 June and 18-20 June Campaigners are urged to support by signing the petition and donating to the strike fund.

The domestic staff warn that if their services were to be transferred into the private sector it would spell 'disaster' for their patients.

Princess Alexandra Hospital currently has one of the lowest rates of infection in England, including instances of MRSA. By contrast cleaners from the hospital have recalled the brief privatisation of services in the 1990s, when Mediguard had to hand back the contract after just one year because of its failure to maintain standards.

The strikes will begin with a single day on June 6, the date of the next Trust board meeting

It's almost exactly 35 years since Margaret Thatcher's government triggered the first strikes by hospital domestics against the imposition of competitive tendering for NHS support service contracts. Widespread privatisation resulted in a massive deterioration in hospital hygiene standards as trusts were forced to accept the lowest bid regardless of quality concerns.

Twenty years later, in 2004 the Department of Health belatedly drew the link between compulsory competitive tendering and declining standards of hygiene and support services. Some have still not learned the lesson: recent research found that private contactors were still delivering services to English trusts, and were "cheaper but dirtier than their inhouse counterparts."

Princess Alexandra staff also warn that their pay and conditions will fall below their NHS colleagues if their services are outsourced, because a private company would not be part of any future NHS pay awards, and new starters could face substantially worse employment terms.

IN THIS ISSUE

Circle's hopes are dashed by High Court

(From front page, top story)

John Lister

Circle Health has been fighting since the beginning of last year to cling on to the contract to deliver services from the Nottingham Treatment Centre. The contract was worth £55m in 2017 (and brought a profit of £2.9m).

Circle has run the centre since the first contract was first offered by New Labour back 2008 - a time when NHS trusts were barred from competing.

The company secured another five-year deal in 2013, but by 2018 the rules had changed, and NHS trusts are now allowed to bid to bring back in-house and re-integrate services that were arbitrarily privatised by the establishment of treatment centres.

Cash-strapped CCGs are lso increasingly looking to cut costs.

Last year Circle complained at the reduced money on offer, which it claimed was insufficient to ensure adequate services at the centre, pulled out of bidding and threatened legal action. These antics secured a further year's extension of contract, but did little to win over the CCGs.

In January this year Circle Nottingham asked the High Court to stop NUH taking over the contract.

Their argument was made no more convincing by Circle apparently inflating the value of the previous 5-year contract, which it insisted had been worth £67m a year, although Circle Nottingham's own accounts show their income has hovered around the £55m mark for the last couple of years.

Since then NUH has become the CCGs' preferred bidder for a new £64m a-year contract, while Circle complains the five-year deal has been unfairly awarded to the Trust and breaches competition law.

In what can be seen in a heavily redacted court document, Circle claimed NUH could not credibly deliver what it estimated to be 16 percent savings on current costs, without impacting patient services.

The private-equity-owned company, which depends upon NHS funding and has never posted an overall profit and notoriously walked away from its failing contract to run Hinchingbrooke Hospital just two years into a 10-year contract, has the brass neck to point to NUH's £30m operational deficit and question its financial viability, arguing the trust would need to rely on government loans, and that this would breach competition law.

Circle must now face up to having lost their largest NHS contract (and one of very few making any profit.)

Circle also argued that NUH's staff costs would be up to 20 percent higher than its own. That's no surprise, since the Nottingham Treatment Centre employs less than one in 10 (just 12) of the consultants who work there, and is heavily dependent upon another 163 NHS-employed consultants with "practising privileges" to do occasional private sessions. Delivering only limited, elective surgery, Circle has never had to carry the costs of emergency and complex cases – all of whom are treated at NUH.

Despite employing all these arguments, this time Circle were not so fortunate in their resort to legal action. Deputy High Court judge Sir Anthony Edwards-Stuart ruled that the CCGs could go ahead and hand the 5-year £320m contract over to NUH from July.

The Nottingham unit, on the QMC site is Europe's biggest treatment centre, and provides NHS-funded services including gynaecology, cardiology and respiratory medicine.

The company must now face up to having lost their largest NHS contract (and one of very few, if not the only one of their contracts making any profit.) Having delayed matters by months before losing their court action Circle has now argung the timescale is too tight for the handover to be achieved in time for a July start.

However *BMA News* last year reported that Nottingham University Hospitals Trust (NUH) which had spent at least £500,000 drawing up its bid to bring the treatment centre in-house, and noted that the move would see patient care much less fragmented in the city.

Now the Trust will be able to make efficiency savings by reintegrating the services, most of which it has had to run in parallel in order to deal with cases too complex for a treatment centre to handle. It would of course also gain a significant extra injection of revenue to cover its extra costs.

The Trust and commissioners now clearly see the benefit in NUH receiving the extra revenue, rather than Circle and its owners.

However we have not heard the last from Circle on this disputed contract. They are still saying they will sue the commissioners for damages from what they say is an "unfair" procurement.

What are the chances the High Court will follow up its judgment in favour of the NHS by suddenly deciding the procurement process they have just endorsed was flawed, and awarding damages to Circle?

Who knows what another judge on another day might decide? Campaigners will need to remain vigilant until the further hearing has taken place later this year.

Private hospital at risk

The even worse news for Circle is that the outcome of the case must also leave the future of its private hospital on the Queens Medical Centre site in doubt, now the building will be taken over by the NHS.NHS patients are not allowed in to it.

Circle had been exploiting the proximity to the NHS to lend prestige and credibility to its range of surgical and diagnostic services for self-pay and insured patients – with eye-watering minimum fees of £12,250 for a knee replacement, £2,265 for an inguinal hernia repair and £2,246 for a cataract operation.

GP At Hand: more questions than answers

The long-awaited and repeatedly-postponed report on Babylon GP At Hand service has finally been published – but anyone hoping for clear answers to clear questions will be disappointed.

The report does confirm suspicions that GP At Hand has predominantly recruited younger, fitter, more affluent patients.

It therefore implicitly concedes that by allocating enhanced resources to them the NHS has effectively drained resources from care of more vulnerable patients and older people with great and more complex health needs.

94% patients enrolled with BGPaH are aged 45 or under, and two thirds of them live in more affluent areas.

Surprisingly this relatively youthful, wealthy and healthy patient cohort is actually also more likely than the average to make use of primary care, 111 and A&E services.

However (p80): "even if additional demand for primary or secondary care services had been observed in BGPaH patients, no conclusions could have been drawn on whether this demand was an appropriate use of healthcare resources."

There are so many other conclusions that also cannot be drawn, according to the 93-page report. It repeatedly calls for further research and investigation.

Among the key issues fudged is the key question of the cost-effectiveness of the model (which cannot be assessed "due to the absence of data on patient outcomes" (effectiveness) – but also a lack of any information or transparency on the costs of the model.

"For commercial sensitivity reasons, no data are available on the costs of maintaining the bank of GPs or the infrastructure development by Babylon."

The report does argue that it could still be cost-effective for the NHS to spend additional money on the BGPaH model … "if the outcomes for patients are sufficiently better than through traditional practice."

But are the outcomes better?

"The evaluation team do not know if this is the case because data on patient presenting problems or outcomes was not available…"

Debt ridden STP shakes a collecting tin

John Lister

It's not that unusual to see large deficits in today's NHS, after almost a decade of brutal austerity limits on funding, but the deficits are so large in the East of England that NHS England/ Improvement's Regional Director is passing round the hat round to five STPs, pressing them each to 'lend' £5m to the sixth, the floundering Cambridgeshire and Peterborough STP.

This has caused some bitter resentment, not least in Norfolk where the press reported an angry lay member of North Norfolk CCG, Peter Franzen, responding sharply to the request for a £5m handout to prop up budgets elsewhere:

"Can I ask how we think the public would feel about another £4-£5m of cuts to a system that's already in debt and being asked to make savings to help another system?"

The extra £25m is barely a drop in the ocean of red ink that has covered the accounts in Cambridgeshire and Peterborough for the fast four years (with end of year deficits in excess of £100m each year since 2015). According to the latest STP Board papers "the underlying exit position for 2018/19 going into 2019/20 was [a deficit of] £212m."

Remarkably even this level of deficit still meant the STP was eligible for £52m of "Provider/ Commissioner Sustainability Funding" (which used to be restricted to trusts that achieved their targets), bringing the C&P "final system outturn" to a deficit of £148m.

Cambridgeshire and Peterborough health bosses are now focused on the huge challenge for 2019/20:

"Over the past few months, System partners have been developing their financial plans for 2019/20, with a System Control Total set of £142m overspend."

Once again the three acute trusts and the CCG have rejected their control totals; their response seems almost surreal:

"Our latest plan is an overspend of £192.4m; this is still £50m away from the System control total but will, subject to the agreement of our regulators, enable us to access a substantial sum of £80.6m of Provider/ Commissioner Sustainability Funding (PSF/CSF) available to this System for those organisations achieving their respective Control Total."

"Our latest plan is an overspend of £192.4m; this is still £50m away from the System control total …"

This is the £192m deficit towards which the other five STPs have now been asked for loans – bringing the deficit down to a mere £167m – and halving the gap from the control total set by NHS Improvement.

Ironically however, Norfolk and Waveney STP which has been press ganged into becoming a grudging donor to this support fund, is itself facing some punitive savings targets in the effort to squeeze their combined deficit down to £16.5m this year, and thereby secure almost £70m of 'sustainability funding'.

The omens are not good: the STP has three major trusts in special measures, and was expected to wind up with a combined deficit of £96m for 2018/19, despite delivering £104m of 'efficiency savings'.

The largest acute trust, Norfolk & Norwich University Hospitals alone ended 2018/19 with a £58.8m deficit, more than £6m worse than planned.

The STP drawn up in 2016 aimed to save £300m by 2021, and expected the system to be £4.5m in surplus by 2018/19. Former New Labour Health Minister Patricia Hewitt who now chairs the STP has admitted the plan was "over optimistic".

But with control totals being wilfully ignored, and huge deficits concealed year after year by handouts of sustainability funding for fear of the consequences of imposing truly massive cuts, it is clear that Regional Director Ann Radmore is deep in denial, claiming against all the evidence that:

"We expect every NHS organisation to live within their means, and the benefit of taking a joined-up regional approach is that we can tackle the issues together."

Her region is set for an overall shortfall this year of £76m: all the covert subsidies, handouts and loans can't hide the fact that the NHS in eastern England – and every other area – is drastically underfunded.

Concordia sheds NHS dermatology contract at short notice

Concordia Specialist Care Services gave just five days notice for the termination of its contract to provide dermatology services to patients in North East Essex earlier this month. The company has now left the contract two months before its end date of July 2019.

No formal reason has been given for leaving the contract, although it is known that the company is restructuring. The contract began in July 2017 and was for five years, but this was reduced to two years by North East Essex CCG last October.

The service provided by Concordia was criticised in a critical CCG report, after team inspected Fryatt Hospital, the base for the Concordia service, in mid 2018.

The CCG report noted: "Standards of hygiene and cleanliness in a number of areas did not comply with national standards, medication was out of date, specimens were inappropriately stored in a medication fridge and Concordia staff were unaware of how to access organisational policies."

The service has been taken over by East Suffolk and North Essex FT and the service's six staff have been transferred to the trust.

An article in the HSJ suggested that the parent company Omnes Healthcare LLP (known as Concordia Health LLP until last week) has financial difficulties, but the company has denied this and says it is restructuring and no other service is affected.

Omnes Healthcare LLP operates under a number of subsidiary names, but primarily Community Outpatients Ltd and Concordia Specialist Care Services Ltd.

The company's Community Outpatients website states it works for over 40 CCGs at over 150 community sites and lists dermatology, ENT, cardiology and endoscopy as services provided.

Concordia is not the first private company to abandon a contract leaving the local NHS services to pick up the work. Earlier this month we reported on Virgin Care terminating part of its contract in East Staffordshire for services for the frail and elderly.

The part of the contract covering the sub-contracting of various services has now moved back to East Staffordshire CCG. This was followed by Virgin Care announcing that it is terminating the entire contract three years early in 2020, arguing that the reason was a failure to come to a financial agreement with the CCG.

"My patient records are missing!"- Capita may know why

Sylvia Davidson

This week it emerged that Capita has wrongly archived 130,000 patient records rather than sending them on to the GPs of newly registered patients. This is the latest in a long chain of failures in its contract to carry out Primary Care Support (PCS) services.

NHS England has stated that there is no evidence of any harm due to the error, but the BMA countered that this judgement was based on only a looking at a small number of records and "the blunder typified the problems that had beset the service since Capita was given the contract."

In 2018, it was found that Capita had failed to send letters to almost 50,000 patients on the cervical cancer screening programme.

As a result, in March 2019, NHS England decided to take the cervical screening programme back in house away from Capita.

An earlier investigation into the contract by the Public Accounts Committee concluded that errors by the company had "potentially... put patients at risk of serious harm" as thousands of GPs, dentists and opticians had been delayed in treating patients.

- A profile of Capita
- Support our campaigning journalism

In July 2018 Capita claimed the problems had been ironed out and NHS England said the contract was delivering savings.

In comments to this week report in the BMJ Richard Vautrey, chair of the BMA's General Practitioners Committee, said, "Capita has consistently proved itself unfit to hold this contract.

NHS England has at last listened to the BMA and now plans to bring cervical smear administration back in house. And with this latest blunder they now must urgently do the same for all of these services."

Capita took over the coordination of primary care support services in September 2015. The contract with NHS England was designed to save £40 million per year by bringing together a previously fragmented service to a single national provider for Primary Care Support England (PCSE).

Capita's bid hinged on making a £21 million per year saving. The contract is worth £330 million over seven years.

Capita immediately began centralising support services to three national hubs and implementing a single online 'portal' for practices to order supplies and 'track' the movement of patient records.

However, since the contract began there has been an never-ending series of problems - ranging from things as mundane as surgeries running out of prescription pads and syringes to far more serious problems with the secure transfer of patient notes around the country, with notes going missing or delivered to the wrong surgery, and women being dropped from the cervical cancer screening programme.

The problems encompassed GPs, dentists, opticians and pharmacists.

A campaign by the GPC (General Practice Council) has been ongoing since early 2016.

Determined strikes at Wrightington, Wigan and Leigh defeated management plans to outsource staff to a new "wholly-owned company" – and appear to have set a new tone of militant resistance by health unions against privatisation and contractors

Fighting privatisation – far from a lost cause

How far has the process of privatisation already gone within the NHS: and how much further is it set to go, given the constraints on funding and political considerations? In this 4-page feature JOHN LISTER takes an in-depth look at the facts.

Earlier this year, in the aftermath of the NHS Long Term Plan, NHS England opened up a discussion of proposals to change or remove sections of the 2012 Health and Social Care Act, notably to remove the requirement on Clinical Commissioning Groups to carve up services and put them out to competitive tender.

There was a distinct change in the language used, as NHS England sought to persuade unions, campaigners and politicians that their agenda was one of "integration", replacing competition between public and private sector for contracts with collaboration and cooperation.

The response has been mixed, with some even dismissing the proposals as a covert, if convoluted, route to further privatisation ("This legal change will not halt the privatisation of the NHS, it will accomplish it!").

Many campaigners have understandably found it difficult to understand the contradictory role of NHS England, which was on the one hand vigorously driving forward with new privatisation initiatives while at the same time professing frustration with the law they were implementing.

The Lowdown has carried numerous reports on the new inroads being made by the private sector into NHS budgets, notably the moves to establish new multi-£billion pathology networks in which private sector providers will be leading or prominent components of consortia, and imaging networks, which are likely to follow the model of the controversial privatised contract for PET-CT scanning in Oxfordshire.

The value of contracts subject to competitive tendering as a percentage of CCG spending on clinical services fell by a third (from 3% to just 2%) between 2015 and 2018

In our last issue we reported plans to include private healthcare companies in decision-making on the allocation of NHS mental health budgets totalling over £2 billion, and (unsuccessful) attempts to involve a large number of private providers in an innovative plan for Child and Adolescent Mental Health services in Kent, Surrey and Sussex.

Some critics and campaigners conclude from these and other manifestations of privatisation that the path leads inexorably to much wider extension of privatisation, with talk of "endgame," and some arguing that NHS England's plans are leading towards a US-style system, complete with US health corporations, charges for care and private insurance.

However it's clear that the private sector sees the situation very differently.

Circle Nottingham management are licking their wounds and counting the cost of their failed legal challenge to the loss of their most lucrative NHS contract – and they are by no means the only private providers who are arguing that the system is increasingly "unfair" and making life difficult for them.

Private sector response

Responding to the NHS England proposals for legislative changes, the Independent Healthcare Providers Network argued that from their point of view they do not want an American-style system based on private health insurance ("The NHS remains and in our view should continue to remain publicly funded and free at the point of use").

Indeed they realise that with most of the people in most need for health care also being those least likely to be able to pay a market price for it or secure health insurance, only government funding can pay for many of the contracts and episodes of care that keep the private sector, and especially private hospitals, afloat.

But the IHPN also went on to attack the "myth" that the NHS is being privatised.

The IHPN began by pointing to their own findings

from Freedom of Information requests to England's CCGs which showed the proportion of NHS contracts awarded through competitive tendering has fallen in recent years, from 12% of all contracts in 2015/16 to 6% the following year, before recovering partly to 9% in 2017/18.

The value of these contracts as a percentage of CCG spending on clinical services has fallen by a third, from 3% to just 2% over the same period.

This is consistent with previous findings from NHS Providers that the private sector has been most successful in winning community health services contracts, with many more contracts than the NHS, but that most of these are small in value, leaving NHS trusts with just 21% of contracts, but 53% of the contracts by value compared with just 5% for the private sector.

Department of Health and Social Care Annual Report figures show the amount spent by the NHS on private providers of clinical services rising each year from 2006, from just over £2 billion to almost £9 billion by 2016, and the private sector share of NHS spending rising from 2.8% to 7.7% over the same period.

However this flat-lined in 2016/17, and declined to £8.7 billion (7.3%) in 2017/18.

Contracting by trusts

The Department annual figures are for CCG spending only, and do not include the contracting out of services by NHS and foundation trusts, so they significantly understate the scale of private sector involvement in the NHS.

Recent research, looking at NHS data for 130 hospital trusts from 2010 to 2014 found that an average

An average of around 40% of hospital trusts still had contracted out cleaning services in 2014, suggesting this service alone was costing around £500m per year.

of around 40% of hospital trusts had contracted out their cleaning services, at an average cost of £3.84m per trust (although there is wide variation) – suggesting this service alone was costing an additional £500m per year five years ago.

We know many other support services have since the 1980s been contracted out to private companies – catering, laundry, security, car parking, patient transport: these too are additional to the DHSC Annual Report figures.

In some areas clinical support services have also been contracted out by trusts, increasing even further the role of the private sector.

Contracts for clinical care

In terms of clinical care, the BMA late last year found that 44% of NHS private spending was on community health services, 25% on general and acute services and 11% on mental health.

The BMA's online report included a useful breakdown of the top 12 private firms, identifying the number of contracts awarded to private providers by the 73 CCGs that responded to FoI requests.

This showed the private acute hospital chains holding the largest numbers of contracts over £50,000, with Spire (52) and BMI (49) followed by Ramsay (28)

44% of NHS private spending was on community health services, 25% on general and acute services and 11 % on mental health

and Nuffield Health (26) together making up more than half the total of 287.

The private hospitals have been keen to cash in on the under-funding and lack of capacity of NHS acute trusts after nine years of reductions in front line beds while the population and pressure on services has increased. Even prestigious teaching hospitals such as King's College hospital in London have been driven to outsource elective care to private hospitals.

As a result, according to the IHPN "elective care is critically dependent on independent sector provision". However this seems to be an exaggeration, to judge from the IHPN's own claim that around 6% of NHS elective admissions are now going to private hospitals. This leaves leaving the NHS to deal with the other 94% – as well as 100% of the emergencies, complex and chronic care.

There is little scope for a major rapid expansion of the private acute hospitals themselves. With a few exceptions the hospitals tend to be very small, averaging just 46 beds, and focused entirely on quick turnover elective treatment. And while private hospital bosses would prefer to be able to fill beds with self-pay and privately insured patients who pay higher fees, there are not enough of these patients around.

So private hospitals have become dependent upon NHS-funded patients (and self-pay patients driven by despair or chronic pain to leapfrog growing NHS waiting lists) to fill otherwise empty beds.

Of course they also depend upon NHS-trained and often NHS-employed medical and nursing staff to deliver treatment and care.

Gloomy view

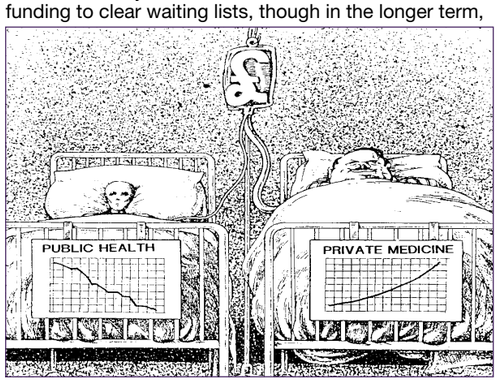
Far from the private sector feeling chipper and anticipating good times ahead, a recent IHPN blog indicates a much less positive mood:

"Private healthcare finds itself at a crunch point. Low (or no) growth across local and international markets, spiralling costs, falling medical insurance subscriptions and "intelligent consumerism" continue to challenge the sector."

This follows on a downbeat assessment of the prospects for private hospitals from market analysts Laing & Buisson in 2018:

"a number of providers face clear challenges. Notably, those which have a heavy reliance on NHS as a customer have faced some market disrupters recently, as growth has grounded.

"Growth may return when the NHS uses additional funding to clear waiting lists, though in the longer term,



Mental health: stronghold of private provision

The NHS reliance on private providers can be much greater in mental health services.

Department of Health figures compiled by the Nuffield Trust showed a massive 24% of mental health spending went to non-NHS providers in 2012/13, and that private provision was growing at the expense of the NHS:

"funding for independent sector mental health service providers increased by 15 per cent in real terms between 2011/12 and 2012/13 alone, while funding for NHS-provided mental health services decreased by 1 per cent". (page 6)

Laing & Buisson estimate 30% of mental health hospital capacity is now in the private sector, and revenue is increasing. A report early in 2018 notes:

"robust revenue growth for independent mental health hospitals in recent years, amounting to 12% in 2015 and

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4% in 2016, though pressure on prices by financially stretched NHS agencies has meant some diminution in profit margins. […]

"… the main driver continues to be the long-term trend towards NHS outsourcing of non-generic mental health hospital treatment, which shows no sign of abating. CCG block contracts with NHS Mental Health Trusts, which give the Trusts little incentive to expand their own in-patient capacity or even maintain what they have, limited NHS capital budgets, and risk averse behaviour of Trusts all contribute to the growth in demand for independent acute mental health bed capacity."

However the imbalance is even more dramatic in child and adolescent mental health: recent reports reveal that no less than 44% of the £355m NHS spending on CAMHS care goes to private providers, and figures given in parliament last November again show how the private sector spend has grown by 27% over 5 years from £122m to £156m, although spending on NHS providers has risen faster (by 40%).

In mental health the private sector domination is most complete in the provision of "locked ward rehabilitation", in which a massive 97% of a £304m market in 2015 was held by private companies

The private sector domination is most complete in the provision of "locked rehabilitation wards", in which a massive 97% of a £304m market in 2015 was held by private companies, the largest of which was the (now merged) Cygnet/Cambian (20-30%), with substantial involvement also of Acadia (Priory Group) with 10-20% and Huntercombe with 5-10%.

The merged Cygnet in 2017 reported operating 2,400 beds across 100 sites, with over 6,000 staff. In the summer of 2018 it also took over the Danshell Group, operating 25 units with 288 beds for adults with learning difficulties. While Cygnet Health Care recorded a loss of £9.4m on turnover of £121m in 2017, the Group reported a very healthy profit of £40m on turnover of £334m.

The increased proportional spend on private providers has made them even more dependent on funding from the NHS to prop up their balance sheets: the most recent accounts of the largest mental health provider, the Priory Group, show that 52% of its income of almost £800m came from the NHS, and another 38% from social care – a total of 90%.

According to the Competition and Markets Authority the market for mental health services was worth a total of £15.9 billion in 2015, 27% of which was for hospital services, and the private hospital sector had grown by 8% in the previous five years, while NHS capacity had been cut by 23%.

market fortunes in this area are difficult to predict."

Another problem faced by would-be private providers of NHS services is that the near-decade of austerity ushered in by David Cameron's government and maintained ever since has meant that many of the contracts that have been offered up for tender have been under-funded.

As a result several private bids have been withdrawn prior to the contracts being awarded leaving only NHS bids on the table, or companies have not even bid at all, or in some cases simply walked away from contracts that were incurring or threatening them with losses.

This happened at Hinchingbrooke Hospital, and with many patient transport services, and contracts in community and primary care.

Virgin recently revealed it will walk away from an underfunded community contract in East Staffordshire, and Concordia's last minute notice of withdrawal from a dermatology contract in Essex (see page 4).

Many of the large-scale Integrated Provider Contracts that campaigners (despite the assurances of NHS England) fear could be opened up for the private sector seem certain to include the more costly, risky and less profitable services that the private sector has always been careful to avoid.

It seems likely any private sector involvement in IPCs or Integrated Care Systems will centre on specific tasks with guaranteed profitable prospects – such as so-called "backroom" services

Targeting potential profit

With this danger in mind it seems likely any private sector involvement in IPCs or Integrated Care Systems will centre on specific tasks with guaranteed profitable prospects – such as so-called "backroom" services handling data, managing processes, drawing up specifications, along the lines tried and tested by UnitedHealth subsidiary Optum in England and in the US; or supplying apps and other IT expertise and equipment; or clinical support such as pathology and imaging contracts.

It's important to remember that private health providers are not in it to make a point, but to make a profit. They don't like risk, and Virgin in particular has seen that 'loss leader' contracts tend to go on not to more profitable contracts but to large losses, or even services being brought back in house.

So while we fight on to resist every further encroachment of the private sector, and aim to roll back the privatisation that has taken place, it's clear that we have a lot of NHS still to defend, and the private sector are far from content with the position they are in.

The increasing combativity of health unions mobilising NHS staff to resist outsourcing of services to "wholly owned companies" – with some successes already achieved – and with contractors' staff currently waging campaigns including strikes to secure parity of pay with NHS staff – there is a strong basis for unions, campaigners and supportive politicians to challenge any and every further attempt to erode our NHS.

● ***The Lowdown*** will take a further more in depth and historical view of privatisation in future issues.

Where does all the "non-NHS" money go in Greater Manchester?

Caroline Bedale

Using private companies to deliver NHS services means taxpayers' money is being used to pay for profits to directors and shareholders.

Since 2013 decisions on commissioning have been in the hands of Clinical Commissioning Groups (CCGs). These have been required by the 2012 Health and Social Care Act to put an increasing range of services out to tender, but in many cases they have been eager to privatise services.

A report by the NHS Support Federation in December 2017 found CCG spending an average of 15% of their commissioning budgets on 'non-NHS providers' – private companies and charities.

Nor is the problem resolved by use of "non-profit" providers. Large voluntary sector and charity organisations provide a lot of NHS services – and while they don't make profits or pay dividends to shareholders, their involvement in providing services means that that funding is taken away from the NHS itself and services are fragmented between many providers.

The voluntary/charitable sector should have an important role to play in making sure disadvantaged groups have a big say in their healthcare and in lobbying for better services: but they should not be providing mainstream NHS healthcare services.

There is also a significant difference between the relatively small amounts paid to local voluntary/charitable sector organisations and much larger amounts to regional/national ones.

Despite devolution in Greater Manchester, where all the councils (which supposedly should as a result have a say over the decisions on NHS plans) are now run by Labour, the private sector and large voluntary/charitable sector still hold contracts for many healthcare services.

Spending on main private providers (over £400,000 total) in Greater Manchester 2017-18

District	Total Healthcare expenditure (£)	Total expenditure on non-public providers (£)	Percentage non-public of total healthcare expenditure
Bolton	353,982,000	44,653,000	12.6
Bury	217,709,000	24,982,000	11.5
Manchester	690,446,000	87,660,000	12.7
Oldham	276,537,000	50,397,000	18.2
Rochdale	273,153,000	39,082,000	14.3
Salford	340,389,000	33,762,591	9.9
Stockport	347,197,000	37,659,000	10.8
Tameside	284,943,000	31,546,560	11.1
Trafford	274,343,000	29,659,853	10.8
Wigan	394,083,000	39,346,603	9.9
Total	**3,452,782,000**	**418,748,607**	**12.1**

Private Hospitals and Surgery – General and Acute		Spending (£)
BMI Healthcare – Alexandra		30,157,822
Ramsay Healthcare		16,098,548
Euxton Hall, Chorley	1,633,995	
Oaklands, Salford	13,713,158	
Neurological Services	526,020	
General	225,375	
Pennine MSK *musculoskeletal*		7,103,770
SpaMedica *eye surgery, cataracts*		6,484,729
Optegra *private eye hospital*		4,408,446
Spire Hospital		2,686,777
Fairfield Independent Hospital, St Helens		2,677,914
Care UK Clinical Services		2,179,294
Manchester Surgical		1,401,726
Marie Stopes International *abortion, IVF*		1,250,790
Beacon Medical Services Ltd *minor surgery*, ENT		1,177,441
Pregnancy Advisory Service /		2,356,850
Total (General and acute)		**77,984,107**

Diagnostic / Assessment / CATS	
InHealth	7,707,861
(inc InHealth Pain Management Solutions £677,854)	
Lancaster House Consulting & Diagnostic & Surgical Ltd.	5,327,000
Mediscan Diagnostic Services	2,141,464
Alliance Medical *diagnostic & molecular imaging*	1,686,391
Durnford Dermatology CATS	1,088,000
Diagnostic Healthcare	841,375
Total diagnostic/CATS	**18,792,091**

Private Hospitals – Mental Health, other mental health services and learning difficulties	Spending (£)
Priory Group, Cheadle Royal	4,784,329
HC-One	3,641,387
Alternative Futures	3,558,270
Cygnet (Universal Health Services)	3,386,621
Cambian Care/Care Tech	3,224,089
Turning Point	3,194,876
Big Life Services/Big Life Co	3,090,088
Self Help Services	2,557,862
Making Space	2,380,279
Elysium Healthcare	2,295,740
Equilibrium Healthcare	2,074,686
Six Degrees	1,490,859
Partnerships in Care	1,272,933
Mind (Manchester, Tameside & Gl)	1,225,754
John Munroe Group Ltd	1,162,903
Transitional Rehab Unit	974,271
Total (mental health and LD)	**40,314,947**

Community Services	
Virgin Care Providers Services Ltd	1,939,268
sexual health (Oldham Public Health)	1,100,000
Turning Point	2,500,000
Specsavers Hearcare	2,345,086
ABL Health	1,501,188
IntraHealth	1,040,476
Totals community services	**10,426,018**

The main private sector providers of CCG-commissioned NHS services with contracts adding up to £1m (or close to it) in Manchester in 2017/18. Total (higher) figures for non-NHS spending will include local government.

Local campaigners wanting to get a full picture of where public money was being spent made Freedom of Information requests to all the 10 Clinical Commissioning Groups in Greater Manchester (CCGs control the funding for most NHS services), asking for expenditure on services from non-NHS / non-public sector organisations in 2017/18.

This revealed a near 100% variation in the percentage of CCG spending flowing to non-NHS providers, with a lowest figure of 9.9% (Wigan and Salford) and a highest of 18.2% in Oldham. Overall the average was 12.1%, equivalent to almost one pound in every eight going outside the NHS.

The collated data also reveals the major players among the private providers, with the private acute hospital chain BMI Healthcare the biggest winner, with contracts totalling over £30m, followed by Ramsay Healthcare which picked up over £16m of contracts, the largest share of which went to its Salford hospital, Oaklands.

Two other private general and acute providers, Pennine MSK and Spa Medica (eye surgery and cataracts) were also well ahead of a list of 12 companies or charities gaining more than £1m contract income from Greater Manchester CCGs.

Among the mental health providers, Priory Group (owners of Ticehurst House in East Sussex, where severe failures of care were recently exposed) topped the list with almost £4.8m, followed by the less well-known HC-One (which was formed out of the collapse of Southern Cross, and put up for sale last summer, and has just been fined for a failure of care in a Scottish care home) with £3.6m.

However both would have been eclipsed if the subsequent merger of US-owned Cygnet (owners of the Durham hospital Whorlton Hall, recently exposed by BBC's Panorama) with Cambian Care/Care Tech had taken place earlier: each company picked up contracts in excess of £3m, and their combined total would have been £6.6m.

Spending on diagnostic services was heavily dominated by InHealth (a company currently in the news for its involvement in a highly controversial PET-CT scanning contract in Oxfordshire) which picked up a total of £7.7m, ahead of Lancaster House with £5.3m.

By contrast with the other services, the scale of contracts awarded for community and public health services are much smaller.

But with a total of £418m flowing out of the CCGs to private providers in Greater Manchester alone in 2017/18, the obvious question is how much better could NHS services be if they were given this extra revenue, and the capital they require to deliver services: and how long can this scale of private spending continue alongside NHS England claims that they want to "integrate" services?

A note on the data

Three of the CCGs, Bury, Manchester, and Stockport would only give the names of private providers but no financial details – saying that 'commercial sensitivity' prevents them from giving out this information.

Previously, at the start of the financial year, Stockport had supplied a table listing providers, service type, service description and contract values for 2017/18 – but in many cases actual financial amounts were not given on the basis that they were activity based contracts or AQP contracts, or that it was a framework agreement, or cost per case, so there was no specific contract value. In some cases specific figures were given. Figures in in the section on Stockport are those given in that table of contract values for 2017/18.

However, all CCGs have to comply with a government requirement to publish any payments they make over £25,000 each month, so this data has been used to provide some additional information about the private / voluntary sector expenditure in those 3 districts.

There were sometimes discrepancies between the financial information supplied by some CCGs and the figures in their Annual Reports, but these were not major and do not distort the overall picture.

This analysis focuses on expenditure on healthcare services which are not provided by the NHS or other public sector bodies (mainly local authorities).

In the CCG information there are substantial amounts being paid to care homes and home care providers for 'continuing health care' (CHC) and 'funded nursing care' (FNC).

These figures are included in the calculations for total healthcare expenditure.

Why can't you get a GP appointment?

How long do people have to wait for a GP appointment?

It is common for patients to have to wait over a week and in some cases much longer for a routine appointment with a GP. Most surgeries run a system for same day appointments, but these slots go quickly, sometimes only minutes after surgeries open.

Waits have increased over the past few years. In the report - NHS Pressure - Winter Crisis 2018/19 - the BMA found that the number of patients waiting over two weeks for an appointment with their GP was up by 13% compared to the same months in 2018.

Appointments with a wait of over 28 days were up 15% on the previous year rising to 2,230,000.

Social media has shown instances of patients queuing outside surgeries before they open in order to get appointments: one person reported that patients in Wellingborough were queuing 75 minutes before surgery opening time.

Why is this happening?

The simple answer is there are not enough GPs. Despite a government promise in 2015 of 5,000 more GPs, data from NHS Digital released in April 2019 shows that there has been a 4% fall in full-time equivalent (FTE) GP numbers between September 2015 and September 2018; there are now 1,180 fewer GPs than three years ago.

A longer term look at GP numbers by The Nuffield Trust concluded that there had been a "recent sustained fall" in GP numbers relative to the size of the UK population. This is something that has not happened since the 1960s.

The fall in GP numbers comes at a time of population growth, according to The Health Foundation, with the number of people registering with GPs up 3% over the past three years. As a result the number of patients per GP has risen by 8%.

Does the situation vary across the country?

Some areas of England are having more trouble than others recruiting and retaining GPs, with areas considered to be deprived or very isolated from large cities having the most difficulties.

Between 2008 and 2017, the number of GPs working in the most deprived 20% of areas fell by 511, in contrast to the wealthiest 20% where 134 additional GPs were recruited. As a result, these areas often have the worst waiting times for appointments.

Nuffield Trust figures for 2018 found that England fared the worst of the four nations, with 58 GPs per 100,000 population, and within England regional differences were marked, with the East of England and North West London having the lowest levels of 54 per 100,000.

The Nuffield Trust also shows that there are significantly fewer GPs per head of population in the more deprived areas of England than in the richer areas. In the most deprived fifth of CCG areas there are 47 GPs per 100,000 people, compared to 53 GPs per 100,000 population in the least deprived fifth of CCG areas.

One notable area is Swale in Kent, a deprived area, where in 2018 one surgery in Shepway had just one GP per 4,196 patients registered and another had one GP per 3,847 registered patients.

As a result of these low GP numbers, patients in deprived areas find it harder to get a GP appointment and have a poorer experience of primary care.

Even in the much more affluent area of Oxfordshire, GP shortages are hitting patients. The Oxford Mail reported that in March 2019 more than 13,900 patients had to wait longer that four weeks for a GP appointment in the area. The CCG area is reported to be 21 GPs short.

Cartoonstock

Between 2008 and 2017, the number of GPs working in the most deprived areas fell by 511, in the wealthiest areas 134 additional GPs were recruited

Why is the number of GPs falling?

The fall in the number of GPs in England is due to a combination of factors, including: a lack of junior doctors entering training to become GPs; a rise in the number of trained GPs leaving the NHS, either to work abroad or taking early retirement; and a rise in the number of GPs choosing to work part-time.

Surveys of GPs have found that the primary reason given by GPs for leaving the NHS, including retiring early, is increasing workload, including administration.

In 2014, a study on GP morale and future plans found that one in five GPs intended to retire within the next five years.

A follow-up study in 2018 published in BMJOpen found that morale had reduced further over the preceding years and almost half had brought forward their plans to leave general practice.

The most common reasons given for leaving sooner than previously planned were work intensity and workload. The heavy workload of GPs is impacting on their health and as a result more and more are planning to either quit the NHS or go part-time.

How many GPs do we need?

The report by the King's Fund, The Health Foundation and the Nuffield Trust, Closing the Gap, noted that the NHS will be 7,000 GPs down in five years time if the current trend continues, despite an increase in training places for GPs.

With the regional discrepancies, however, this will mean that some areas, will feel this shortfall much sooner than others; GP Online confirmed that GP numbers are falling fastest in the most deprived areas.

What is being done to increase the number of GPs?

In 2015, the government promised 5,000 more GPs by 2020. The main target for NHS England has been an increase in training and recruitment of GPs from abroad.

In 2016, the 'golden hello' was introduced for trainee GPs who applied for places in certain areas, that found it difficult to attract trainees.

The trainees were given a £20,000 payment for agreeing to stay for three years of training in the area. The 2018-19 scheme filled its 265 places.

There has also been an expansion of training places overall, with a record number entering training in 2018/19, according to NHS England.

NHS England is also recruiting GPs from abroad. The international recruitment scheme was launched in April 2016 with a target of 500 GPs by 2020.

It was relaunched in August 2017 with an increased target of 2,000-3,000 GPs by 2020.

Are the incentives working?

The simple answer is no, the data published in April 2019 clearly shows that despite incentives from NHS England, there is no way the NHS is going to have 5,000 more GPs by 2020.

In January 2019 the Health and Social Care Secretary admitted that the 2020 date was no longer a target, but failed to set a new target date.

In February 2019, CCGs involved in international recruitment process reported that they have had to cut their targets and NHS England admitted that only just over 70 GPs have been recruited so far and only 50 of these have entered the country. Despite this the scheme has been extended to 2023/24.

In May 2019, recruiters involved in the process, told Pulse that Brexit is putting off potential GPs, even those GPs seeking to return from Australia.

What does the future look like?

NHS England are hoping to ease the pressure by creating new collaborations to share GP work, with pharmacists and Physiotherapists and by grouping GPs into bigger practices.

This strategy appears to acknowledge that the GP recruitment strategy is failing and puts new emphasis on attempting to manage demand through different ways of working.

Local GP practices are being asked to merge together in to Primary Care Networks serving 30-50000 patients each.

They will keep their existing GMS contracts and their current relationship as part of the wider NHS network, but by agreeing to the change they will access new funding to take on seven new areas of work including; structured medication reviews, enhanced health in care homes, anticipatory care (with community services), and work on early cancer diagnosis.

The Kings Fund cites the fact that Wales, Scotland and Northern Ireland have already implemented similar models:

"In Scotland, a key feature of the new GP contract has been the obligation to become part of a geographical quality cluster."

The think tank reports that these have generally worked well, except when covering a mix of urban and rural practices that face different issues.

However GP practice leaders are worried that the new structures mask a likely increase in workload, over 50% supported this view in a survey report by GP online. This is a concern which could well stem from the NHS long term plan, which has a headline goal to transfer more treatment out of hospital and into the community.

The Government has chosen to target training and international recruitment, despite the overwhelming evidence that GP retention is a major problem

What should the Government be doing?

Health commentators are agreed on the urgent need for a well funding national workforce strategy, a document that, several months on from the NHS plan, has yet to be published.

The Government has chosen to target training and international recruitment, despite the overwhelming evidence that GP retention is a major problem.

At the moment, the numbers of doctors training to be GPs may have increased, but without changes to the working conditions, it is unlikely that enough will stay in the profession.

At present, primary care is in a vicious circle - as GPs leave and are not replaced working conditions for the remaining GPs get worse causing more to leave.

Manageable workloads, support for staff wellbeing and strategies to prevent dangerous stress are all needed to keep GPs working according to many GP organisations

In May 2019, the Royal College of GPs published Fit for the Future – in 3,000 GPs talk about what will make a difference.

This included an end to the 10 minute appointment, with patients able to have 15 minute or longer appointments, improvements in continuity of care and an end to isolated working.

For the college's vision of the future to work, the report states that changes will have to be made, including: "general practice receives at least 11% of the NHS budget in all four nations of the UK; the full-time equivalent GP workforce expands by thousands, as does the wider practice team workforce; and that GP specialty training is extended to at least four years to expose trainees to the full breadth of skills and conditions they are likely to need and see in general practice."

THE lowdown

Who we are – and why we are launching *The Lowdown*

The Lowdown launched earlier in February 2019 with our first pilot issue and a searchable *website.*

Since then we have published every 2 weeks as a source of evidence-based journalism and research on the NHS – something that that isn't currently available to NHS supporters.

We are seeking **your support** to help establish it as an important new resource that will help to create enduring protection for the NHS and its staff.

Our mission is to inform, explain, analyse and investigate issues and ensure that the founding principles of the NHS are upheld, in policy and practice.

Information is power, and we aim to provide people with the information tools they need to negotiate, communicate, campaign and lobby in defence of the NHS.

We will summarise news from across the media and health journals, provide critical analysis, and where necessary highlight news that might otherwise be missed, and make complex proposals understandable through a range of briefings. We will bring stories and insights you won't find anywhere else.

And we are keen to follow up YOUR stories and ideas. We welcome your input and feedback to help shape what we do.

Paul Evans of the NHS Support Federation and **Dr John Lister** (London Health Emergency, Keep Our NHS Public and Health Campaigns Together) have almost 60 years combined experience between them as researchers and campaigners.

They are now leading this work to recruit and train new experts, and create a professionally-run news and investigation unit to inform NHS supporters and workers.

This package is therefore something quite new, and a genuine step-up in the resources that are currently available.

As we go we will build an online archive of briefings and articles, and use the experiences and comments of NHS staff and **users to support and guide our work.**

In time we believe this will become a resource that will establish credibility with academics and journalists and which they will use to support inform and improve their own work.

The project aims to be self-sustaining, enabling it also to recruit and train new journalists, and undertake investigations and research that other organisations aren't able to take on.

By donating and backing the mission of the project, our supporters will help develop this new resource, ensuring it is freely available to campaigners and activists, get first sight of each issue, and be able to choose more personalised content.

Why is it needed?

Public support for the NHS is high: but understanding about the issues that it faces is too low, and there is too much misinformation on social media.

The mainstream news media focuses on fast-moving stories and has less time for analysis or to put health stories into context.

NHS supporters do not have a regular source of health news analysis tailored to their needs, that is professionally-produced and which can speak to a wide audience.

In our first year we will:

- establish a regular one-stop summary of key health and social care news and policy
- produce articles highlighting the strengths of the NHS as a model and its achievements
- maintain a consistent, evidence-based critique of all forms of privatisation
- publish analysis of health policies and strategies, including the forthcoming 10-year NHS plan
- write explainer articles and produce infographics to promote wider understanding
- create a website that will give free access to the main content for all those wanting the facts
- pursue special investigations into key issues of concern, including those flagged up by supporters
- connect our content with campaigns and action, both locally and nationally

Help us make this information available to all

We really want to run this publication without clumsy paywalls that would exclude many activists – but if we are to develop new expertise we do need to recruit staff, and so we need the resources to pay them.

We are therefore planning to fund the publication through **donations from supporting organisations and individuals** – and we are very grateful for those individuals and organisations who have already given or promised generous donations to enable us to start the project going.

Our business plan for the longer term includes promotion of *The Lowdown* on social media and through partner organisations, and to develop a longer-term network of supporters who pay smaller amounts each month or each year to sustain the publication as a resource.

But we still need funding up front to get under way and recruit additional journalists, so right now we are asking those who can to as much as you can afford to help us ensure we can launch it strongly and develop a wider base of support to keep it going.

We would suggest £5 per month/£50 per year for individuals, and at least £10 per month/£100 per year for organisations.

Supporters will be able to choose how, and how often to receive information, and are welcome to share it.

On the website we will gratefully acknowledge all of the founding donations that enable us to get this project off the ground.

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

- If you would like us to send a speaker to your meeting to discuss the project, or have any other queries or suggestions for stories we should be covering, contact us at contactus@lowdownnhs.info