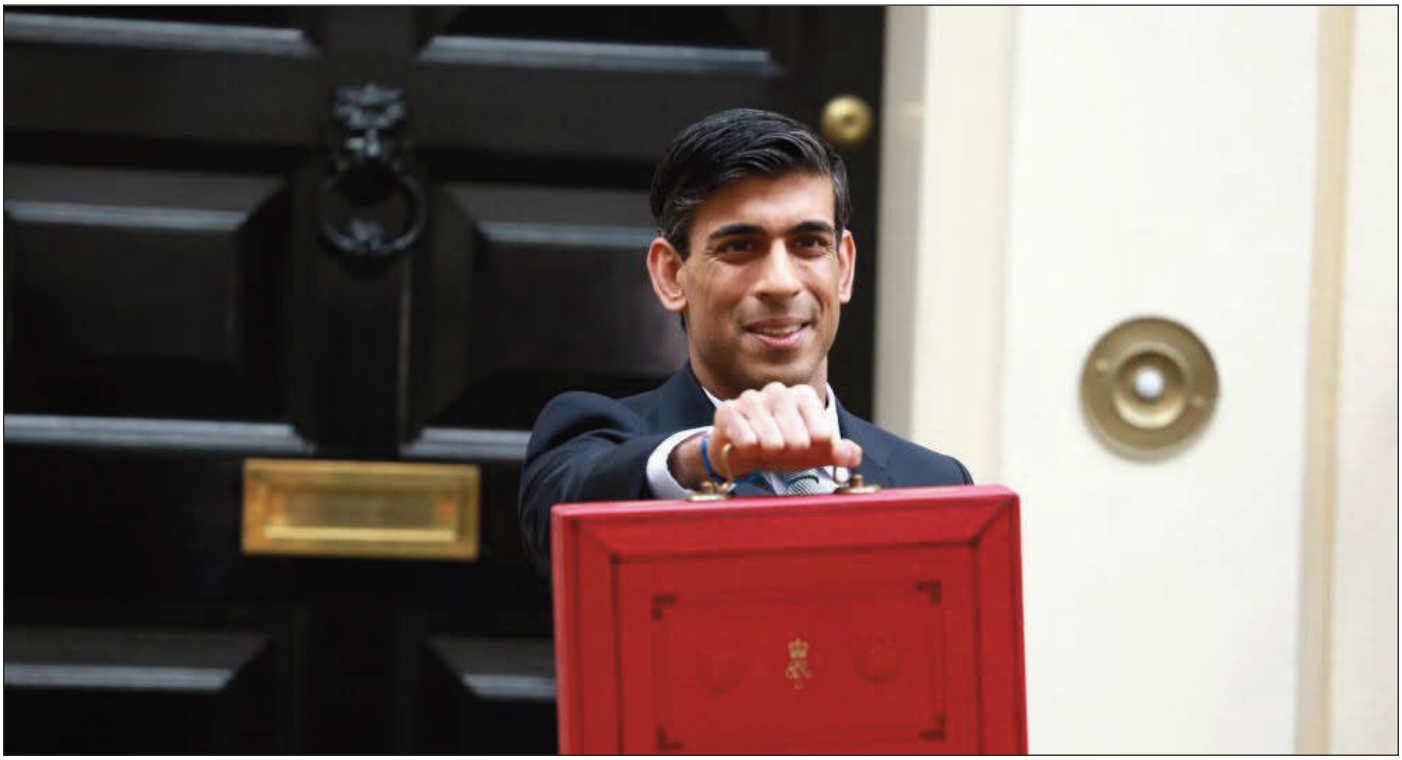
The lowdown

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

Budget letdown: NHS faces record waiting lists and staff 'exodus'



THERE WAS NO SIGNIFICANT new money for the NHS in Rishi Sunak's first budget of 2021, with an extra £1.6bn for the vaccination programme a small gesture, and it was totally silent on social care. As widely predicted, the requests for new money to enable the NHS to recover from the Covid-19 pandemic from NHS leaders, GP leaders and health unions have been ignored.

In fact, it is worse than just no new money, in the red book published alongside Sunak's budget statement, the NHS England (NHSE) budget is shown to fall from £148bn in 2020/21 to £139bn in 2021/22. In 2020/21 NHSE got £18bn in extra funding for its covid-19 response, in 2021/22 it will get just £3bn in extra funding, although the cost of the covid-19 response is unlikely to have fallen so sharply.

The same goes for the total spending at the Department

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of Health & Social Care (including NHSE) – in 2020/21 it is due to be £199.2bn, which includes £58.9bn in extra money to cover covid-19 spending, but in 2021/22 this total spending will fall to £169.1bn, which includes just £22bn for covid-19 response purposes.

There has been considerable criticism of Sunak's budget and its lack of support for the NHS and social care from politicians, NHS leaders, unions and NHS commentators.

Jonathan Ashworth, the shadow health secretary, said, "Rishi Sunak promised to be 'open and honest' with the British public. But buried in the small print of his budget is a cut to frontline NHS services that will increase pressure on staff and do nothing for patients stuck on growing waiting lists."

Saffron Cordery, deputy chief executive of NHS Providers, which speaks for hospital trusts in England, urges "the government to reaffirm its commitment to giving the NHS whatever it needs to deal with covid-19."

Dr Jennifer Dixon, chief executive of the Health Foundation, noted that the budget statement is, "A cause for alarm for the NHS and social care too." Noting that the budget does not provide sufficient funding "to support the direct costs of managing covid-19 in 2021/22 and beyond", and raises major concerns about how the NHS will deal with the huge backlog of care, the increased demand for mental health services and make any sort of progress towards modernisation or investment in the NHS's workforce.

No mention of pay rises

The budget also made no mention of pay rises for public sector staff, something called for by many healthcare unions, including the Royal College of Nursing, Unison and the Royal College of Midwives, nor the additional funding requested by GP leaders to guarantee that patients can continue to access normal services, and the GP and primary care workforce can be expanded.

Unison's head of health Sara Gorton, who chairs the NHS group of unions, said the lack of pay rise will mean that, "The NHS faces an exodus after the pandemic as staff leave".

Medical unions, including the Society for Acute Medicine, also warned about the gap in funding and that the government risked a loss of senior staff over its plans to freeze the lifetime allowance for pensions which could leave more doctors facing large tax bills.

Dr Susan Crossland, president of the Society for Acute Medicine, said, "It is extremely demoralising to see barely a mention of the gaping holes that currently exist in the funding of the NHS… There is also the elephant in the room which poses a significant challenge for the future, and that is the lack of action to resolve taxes on doctors' pensions which could result in a tranche of senior medics reducing working hours or retiring early to avoid huge tax bills."

Prior to the budget, NHS leaders had called for another £10bn for the NHS to enable it to go some way to reduce the huge backlog of operations, cope with the increase in demand from patients with 'long covid' and people needing mental health services.

Funding was already low

Before the pandemic, the NHS was just entering the second year of the Long Term Plan (LTP), attached to which was real-terms funding growth of around 3.3 per cent per year for NHSE's budget (this excludes budgets for several other health-related services, including public health and health education).

This increase in funding at the time was considered to be much too low and that without extra funding and a workforce plan that solves the current staffing crisis the LTP was undeliverable. This extra funding would have been just enough to keep the NHS on its feet but would not have provided a long-term solution for improving services and keeping up with increasing demands.

Now the situation the NHS finds itself in is a million miles away from early 2020, with billions in extra costs associated with covid-19, including maintaining a test and trace system, infection prevention and continued roll-out of vaccines. The Health Foundation has predicted these costs as around £27bn in 2021/22, but Sunak's budget contains only £22bn to tackle these extra costs.

None of this extra spending contributes to realising the LTP for modernising and transforming services, nor does it contribute to coping with any increase in demand due to covid-19 or to the workforce plan. The NHS continues to face staff shortages, with around 100,000 vacancies.

The Health Foundation has calculated that, excluding the costs associated with directly managing covid-19, the cost of restoring waiting times, additional mental health demand and lower productivity will mean the NHS will need around £10bn extra for 2021/22.

In addition, the workforce plan will need up to £1bn extra a year in each of the next three years, public health will need an extra £3bn, and an additional £1bn a year will be needed for capital investment in the NHS. The conclusion is that without this investment, the NHS will not deliver the LTP, nor will it be resilient enough to weather future health shocks.

Sylvia Davidson

Private sector unfazed by new NHS White Paper

PRIVATE HEALTH BOSSES and analysts do not share the conviction of many campaigners that the new NHS White Paper and the establishment of Integrated Care Systems (ICSs) with statutory powers will open up a fresh wave of privatisation. .

Indeed there is little excitement or interest in ICSs. That's the clear message from the latest issue of Healthcare Markets magazine, produced by leading private sector analyst Laing-Buisson.

The coverage of the Bill is not especially extensive, and the main message is that despite the government spin suggesting that the white paper heralds the end of the age of competitive tendering, the new proposals will essentially make little difference to the core contracts and flow of NHS funds in to the private sector.

David Hare, chief executive of the private sector's lobby group the Independent Healthcare Providers Network (IHPN), reminds readers that, despite the attempts in the Cameron coalition government's 2012 Health and Social Care Act to make it compulsory, "The reality is that competitive tendering has always been a minority sport in the NHS, with just 2 per cent of NHS contracts by value let by competitive tender in recent years, so the impact risks being overstated."

Little impact on larger contracts

Indeed the bulk of the clinical contracts won by the private sector in recent years have been relatively low-value community health contracts. Back in 2019, findings from IHPN Freedom of Information Act requests to England's clinical commissioning groups (CCGs) showed the proportion of NHS contracts awarded through competitive tendering had fallen from 12 per cent of all contracts in 2015/16 to 6 per cent the following year, before recovering partly to 9 per cent in 2017/18.

However the value of these contracts as a percentage of CCG spending on clinical services had fallen from 3 per cent to just 2 per cent over the same period. NHS Providers had also found while the private sector had won many more community health services contracts than the NHS, the 21 per cent of contracts won by NHS trusts represented 53 per cent of the contracts by value.

Now Laing-Buisson boss William Laing concedes the white paper could mean that contracting out of community health services might "grind to a halt", affecting firms like Virgin Care, Serco and Mitie, but it was unlikely to have much impact on the big money contracts – mental health, elective care and diagnostic services, where the NHS lacks sufficient in-house capacity.

"The government's new policy probably won't make much difference in most market segments because the NHS uses the independent sector mainly to do things it can't do itself."

Private bosses are also pleased to see the white paper retains "patient choice" and includes "clearer rules on the circumstances and processes around the operation of Any Qualified Provider".

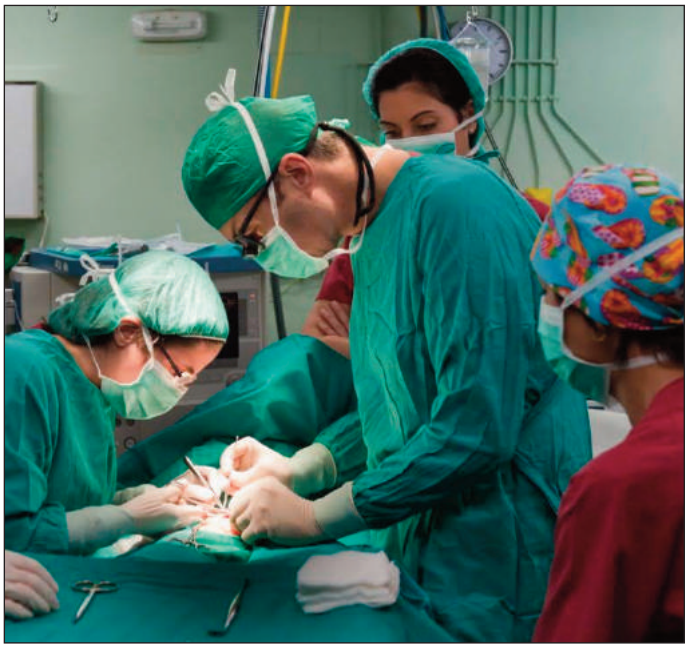
A comment article from Tim Read of the US-based Marwood Group begins by marvelling at the low-key Labour response which indicated "the extent to which the Conservative Party has managed to gain the centre ground on NHS reform".

Read also emphasises that "it is unlikely to mean wholesale change overnight. Ultimately, the independent sector is heavily enmeshed into the fabric of service delivery…" Indeed "in mental health any reduction in the use of private sector high-acuity services would first require significant investment in the NHS mental health estate" – and we all know that's not going to happen.

Read also predicts that with "political alignment" in parliament plus covid and Brexit issues in the media, the "critically important Bill" is unlikely to be subject to the "intensity of scrutiny that health reform would normally attract".

Hare also tellingly points to the 225,000 patients now waiting over a year for NHS treatment, and reassures private sector bosses that with no relief in sight for the public sector, "independent healthcare providers will continue to be vital in supporting the NHS over coming years".

John Lister



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‘Whatever it takes’ pledge ditched as Budget ignores NHS problems

THE INADEQUATE SUPPORT for the NHS and social care contained in last week’s business-focused Budget – coming as it does against a background of billions wasted on private sector contracts during the pandemic, and representing a reversal of the Chancellor’s earlier ‘blank cheque’ stance – reflects poorly on the government’s commitment to sustainable long-term investment in the health service.

Analysis last month by NHS Providers (NHSP) of the delayed NHS 2019-20 annual accounts shows that the service’s finances were already stretched and deteriorating going into the pandemic, despite the funding settlement linked to the Long Term Plan.

Total provider deficit rose by almost £80m year-on-year, to £910m, largely because the overall NHS England (NHSE) budget “had not risen fast enough to meet the rapidly growing demands presented by an ageing population, more complex long-term conditions and technological advancement”.

NHSP went on to highlight the considerable diversion of funding – including a one-off transfer of £1bn – into the acute sector, to the detriment of the financial position of providers in the mental health, ambulance, specialist and community sectors, just as mental health and community services reported significant additional demand.

And despite a £500m rise in ‘everyday’ capital expenditure in 2019-20, NHSP also noted that the cost of the capital maintenance backlog grew 40 per cent over this period, to £9bn.

Last week’s Budget did little to address the challenges presented by an increasingly outdated NHS estate during the pandemic – such as hospitals struggling to maintain adequate flows of oxygen, and difficulties in rapidly expanding or repurposing older facilities to deal with large numbers of critically ill patients – and represents a continuing failure to restore funding on the NHS and social care to pre-2010 levels.

Decade of underinvestment

In an earlier NHSP report, published shortly after the 2019 general election, the organisation pointed out that if NHS and social care spending had risen annually in line with the average before the coalition government was elected in 2010, the Department of Health & Social Care’s (DHSC) budget would have already been £35bn higher.

Those ten years of real-term cuts led to the loss of 9,000 general and acute hospital beds, along with 5,200 mental health beds – a deficit now made all the worse by the closure of thousands more during the pandemic due to infection control, social distancing and the transfer of staff to covid wards and intensive care units (ICUs).

What little health service-related financial support there was in the Budget pertained to vaccine development and distribution, thought to be worth around £1.65bn. The 'red book' published alongside the Chancellor's statement revealed that NHSE was set to get £9bn less over the coming year, compared to 2020-21.

The Treasury appears to be slashing the emergency pandemic funding received by the DHSC last year by more than 60 per cent for 2021-22, presumably on the assumption that the extra costs resulting from covid-19 will plummet once the vaccine rollout gains traction.

Extra funding still needed after the pandemic

That's an assumption not shared by organisations like the Health Foundation, which suggests that at least £10bn more this year is needed to meet the ongoing costs of the pandemic, notably for the huge backlog of elective surgery (in December, almost 225,000 patients had waited more than a year for treatment, and more than 4.5m 'referral to treatment' patients were waiting to start treatment, according to NHSE) and the extra demand for mental health services.

This reduction in support for the NHS, while the long-term impact of covid-19 is still not clearly understood, appears dangerously premature. NHSP chief executive Chris Hopson worries that there has been remarkably little commentary on what the NHS needs to do to live with the virus over the longer term.

In a statement issued last month, Hopson says, "As HIV has shown, we can inoculate ourselves against the effects of viruses and manage their impact through ever more effective treatments. But viruses have a nasty habit of persisting in the community for a long time. This will have profound consequences for the NHS for many years to come."

He maintains that, in order to cope long term with covid-19, a sustainable workforce model – one that doesn't depend on volunteers, or on diverting GPs and NHS trust staff from their existing roles – to deliver a national vaccination programme for years to come will need to be developed.

Hopson also argues that the current 'test and trace' set-up needs quickly bringing up to the standards seen in south-east Asia and in countries like Canada, and that significant hospital bed, ICU and ambulance 'surge capacity' or 'buffer' needs to be created as the virus persists and mutates.

"Whichever number you look at – beds, nurses, doctors or diagnostic equipment – the resources [currently] available to the NHS compare poorly with key comparators like France and Germany," he adds.

So the Chancellor's failure in this month's Budget to bolster the five-year funding settlement agreed with NHSE in 2018 – awarding it an average increase of just 3.4 per cent a year above inflation until 2023/24 – with extra cash to cope with the long-term impact of covid-19 looks mean spirited, to say the least.

Even when the five-year funding settlement was first announced, more than 12 months before the pandemic, the cash on offer was seen as barely sufficient.

The Health Foundation, in conjunction with the Institute for Fiscal Studies, estimated at the time that the figure of 3.4 per cent was below the level required to further improve and modernise the NHS, and that the extra investment was "just enough to maintain current standards".

Little allowance had been made for rising pharmaceutical costs, an ageing population or rising demand, the latter particularly due to multi-morbidity chronic disease.

No mention of nurse recruitment or remuneration was made in last week's Budget either, despite the heroic contribution of NHS staff during the pandemic and concerns over an 'exodus' from the health service because of stress levels and low salaries.

Vacancy rates among nurses across England have remained static – around 10 per cent, or 36,500 – for the past two years, and have actually increased in the South East (to 11.6 per cent), contrary to widely disputed government assertions about being firmly on track to delivering 50,000 additional nurses by 2024.

A miserly response

However, the news last week that NHS salaries were set to rise by a miserly 1 per cent – based on the government's own recommendation to an independent pay review body – unsurprisingly hit the headlines and generated threats of strike action from trade union Unite and the Royal College of Nursing.

Subsequent analysis by the TUC shows that the figure of 1 per cent represents a drop of £2,500pa in real terms, compared to 2010 salary levels.

So… has the Chancellor lived up to his March 2020 Budget pledge to provide the NHS with 'whatever it takes'? The evidence in his latest Budget sadly points in the other direction, but one can only hope the government – reportedly happy to have paid staff from Boston Consulting Group £6,000 a day to work on the state-funded but privately run test-and-trace programme last year – backs down in the face of public opinion and at least ups the pay offer to nurses. Such u-turns have not been unknown in recent months.

Martin Shelley

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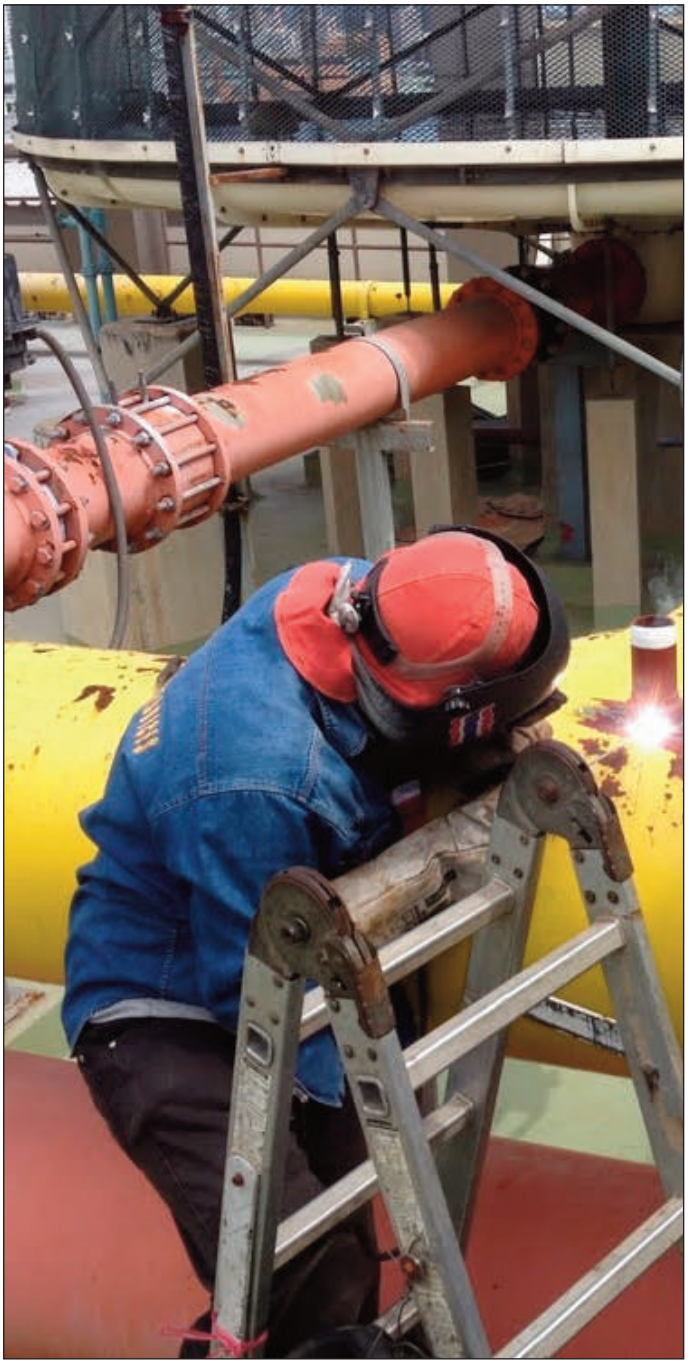
This Budget is a short-sighted prescription for decline in the NHS



RISHI SUNAK'S BUDGET said next to nothing about the NHS, and thus indicates a continuation of austerity-driven spending limits on the NHS after the decade of disinvestment and decline since 2010.

But another major concern is the absence in the budget of any increased capital investment into the England's NHS to tackle the massive £9bn backlog for maintenance – which according to the latest ERIC figures rose almost 40 per cent in 2019-20, and is now almost as large as the whole of the current Department of Health & Social Care (DHSC) capital budget, and the cost of running the entire NHS estate (now around £9.7bn).

The estimated cost of rectifying "high risk" maintenance is £1.5bn, with another £3.1bn required to tackle "significant risk" and £3.2bn for work to tackle 'moderate risk'.

To give an idea of the relative scale of this problem, one expert told Healthcare Design & Management: "Five years ago I was talking about the ticking timebomb of backlog maintenance, which was then around £5bn, and now it's nearly double that.

"When you think the whole NHS capital budget is around £4.5bn a year, then even if we did nothing else for the next two years but spend it on backlog maintenance, we wouldn't address all the issues, and more would build up. The ones deemed to be 'significant' risk would then become 'high' risk very quickly. It is quite alarming."

The problem has been worsened by years of NHS trusts dipping into capital budgets to help reduce of revenue overspends, and to make matters worse the 2019/20 year began with NHS England demanding trusts cut back on their capital spending plans when it became clear that if all of the plans proceeded together they would overshoot the DHSC's capital departmental spending limit.

High-risk management

In the summer of 2019 NHS Providers (NHSP) said in a letter to trust chief executives and finance directors that the lack of capital posed "considerable reputational risk for trusts and the NHS," and warned: "One description of the current situation is that trusts are facing significant patient safety and operational risks."

Now in response to the shocking rise in the backlog – which ran up to March 2020, and therefore does not include much of the pandemic impact – Chris Hopson, chief executive of NHS Providers, said: "It shows how rapidly our very-old NHS estate is falling into disrepair, putting patient lives at greater risk and making it much more difficult for frontline staff to provide the right quality of care.

"More worrying still, over half of this is for work of 'high' or 'significant' risk. In short, this problem poses an increasing threat to safety. It's also impacting directly on the response to the pandemic."

Last year 45 per cent of NHS trust leaders surveyed by NHSP

reported their estate was in poor or very poor condition.

As Hopson suggested, the estates figures show clinical service incidents caused by estates or infrastructure failure have now increased in each of the past three years to 5908 in England's 224 trusts. The trusts with the largest number of estates-related clinical incidents in 2019/20 include Guy's and St Thomas's (612), North East London FT (375) Moorfields Eye Hospital (353), East Suffolk and North Essex (329), Lewisham & Greenwich (273) and Southport and Ormskirk (240).

Clinical incidents not always identified

A clinical incident is one caused by estates and infrastructure failure which results in clinical services involving five or more patients being delayed by at least 30 minutes, cancelled or otherwise interfered with, including where estates and infrastructures failed to mitigated against external incidents (eg utility power failures where the trust's backup power system failed to offset.)

There are questions over how fully these figures are reported, however, since several trusts in responding to Freedom of Information Act requests have stated, like East Sussex Healthcare, that their incident reporting system "does not identify if an incident is a 'clinical service incident'".

Evidence of the impact of disrepair can be found in some annual reports. Pennine Acute Hospitals, for example, reported on the list of issues.

"In July 2019, the Northern Care Alliance [an NHS Group formed by bringing together Pennines with Salford Royal NHS Foundation Trust] was granted a £9.95m emergency capital loan from NHS Improvement/England. Almost half was invested in the heating and energy infrastructure at North Manchester and Oldham hospitals, with the remaining funds being invested to support water safety works, fire alarm upgrades, roof repairs, emergency lighting systems, estates asset management systems, medical gases, windows, fire doors and fire compartmentalisation works."

Just as well the money was made available.

By contrast Southampton notes the poor state of the estate led to a poorer rating from the CQC: "Maternity received a 'good' rating overall and in all individual categories other than safety which recorded a 'requires improvement' rating, while outpatient services were rated 'requires improvement' – both largely due to the quality and age of the estates and facilities"

University Hospitals Morecambe Bay report bravely battling on against the odds: "Despite outlining our case for investment and the real, adverse effect our estate has on continuity, productivity, patient experience and money, we have nonetheless maintained operational performance."

Harlow's Princess Alexandra Hospital, one of those on the government's list of six new hospital projects to which real funding has been allocated, note that they will have to keep services running in the old building until at least 2025, and rank the "concerns about potential failure of the trust's estate and infrastructure and consequences for service delivery" as one of their greatest risks.

In addition to clinical incidents, ERIC figures record almost 13,000 other "estates and facilities related incidents" during 2019/20, with problems concentrated in some trusts. University Hospital Southampton topped the failure league, notching up an average of almost two incidents per day (727 for the year, in addition to 300 false fire alarms).

Other trusts in the top ten of estate incidents include North Bristol (598); Morecambe Bay (594); Pennines (436); Princess Alexandra (408) Barts (392); Sheffield Teaching Hospitals (380); NE London FT (366) Bolton (347 and Moorfields (317). Ten more trusts had 200 or more, and another 20 trusts had over 100 incidents.

Moreover England's NHS trust reported a grim total of 1,693 "RIDDOR" incidents linked to estates. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations which came into force in April 2013 put a requirement on the Trust to ensure that certain major injuries, occupational diseases and dangerous occurrences that occur as a result or in connection with the work done in the Trust, are reported to the Incident Contact Centre (ICC). It is a legal requirement to report a 'RIDDOR' and failure to do so could lead to prosecution.

Investment needed for post-covid future

Of course the NHS capital programme should be about much more than tackling backlogs and preventing safety hazards: equipment needs regular upgrades to keep pace with new technology, many trusts need to refurbish or replace buildings dating back to before the NHS, and many more hospital buildings are upwards of 45 years old.

But while plans drawn up prior to the pandemic for new hospitals now need to be revisited and re-costed, coping with the aftermath of covid-19 also requires capital. Without additional money for investment there is no realistic prospect of remodelling many hospitals to adapt to the post-covid need for social distancing and improved infection control, reopening thousands of closed beds and restoring their capacity to treat routine and emergency patients as well as covid.

Rishi Sunak's budget has turned out not to be a forward looking plan at all, but a prescription for further, dangerous decline. He must be told to think again before more deterioration is reported in the next ERIC figures – to be compiled in October

John Lister

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Call for investigation into Centene takeover of London GP surgeries

CAMPAIGNERS AGAINST privatisation of the NHS have written to Matt Hancock, Secretary of State for Health and Social Care, questioning the legality of the recent takeover of large numbers of GP surgeries in London by the US Corporation Centene following its acquisition of the UK company AT Medics.

In February 2021, Centene, via its UK subsidiary Operose Health Ltd, acquired AT Medics, which operates 49 GP surgeries across 19 London boroughs under Alternative Provider of Medical Services (APMS) contracts and standard contracts, providing services to around 370,000 people, with 900 employees. Until its takeover, AT Medics, was owned by six GP directors.

The campaigners, including Allyson Pollack, director of the Newcastle University Centre for Excellence in Regulatory Science, Peter Roderick, Principal Research Associate, Newcastle University, Jackie Applebee, Chair, Doctors in Unite, Louise Irvine, Secretary, Health Campaigns Together, John Puntis, co-Chair, Keep Our NHS Public, Paul Evans, Director, NHS Support Federation, Steve Carne, 999 Call for the NHS, and Brian Fisher, Chair, Socialist Health Association, question the lack of transparency surrounding the takeover and whether the correct legal processes have been followed by all those involved - AT Medics, 13 Clinical Commissioning Groups (CCGs) and NHS England.

"The campaigners question the lack of transparency surrounding the takeover, and whether the correct legal processes have been followed"

The letter requests that the Secretary of State exercises his power under section 48 of the Health and Social Care Act 2008 to request the Care Quality Commission conduct an investigation into NHS England and the 13 CCGs involved in authorising the take-over of the GP surgery contracts held by AT Medics.

Under APMS contracts, such as those held by AT

Medics, the "contractor must not sell, assign or otherwise dispose of the benefit of any of its rights under the APMS contract without the prior consent of [NHS England]". At some point in 2020, AT Medics Ltd sought prior authorisation from commissioners for the takeover and the transfer of the APMS contracts to Operose Health Ltd. and CCGs began the process to approve the change of ownership.

An investigation by the campaigners, however, has found a "lack of openness, transparency and misrepresentation" by the CCGs involved. The 13 CCGs involved - Barking & Dagenham, Brent, Central London, City & Hackney, Hammersmith & Fulham, Harrow, Newham, North Central London (NCL), Redbridge, Tower Hamlets, West London, South West London and South East London - have published very few documents on the change of ownership and held no public meetings.

The Lowdown's story on the takeover published two weeks ago was triggered by documentation seen by a member of the public involved as a part of a patient participation group at one of AT Medics' surgeries.

Where CCGs have published information, such as North Central London (NCL) CCG, there were no meetings where the public could participate and any mention of Centene was not put in the public domain until after the CCG had made its decision.

Changes not reported

On 17 December 2020, conditional authorisation was given for a change of contractor for the APMS contracts at eight practices in Camden, Islington and Haringey, by NCL CCG's Primary Care Commissioning Committee at a virtual meeting; the public were not allowed to participate. At this meeting the presenter also said that there would be no change of directors at AT Medics, despite the change of ownership; this later transpired to not be the case.

The investigation by the campaigners has also brought to light a previous change of control for AT Medics Ltd in 2019, when it changed from a Ltd company to a Limited Liability Partnership (LLP), that the campaigners believe should have been reported to the CCGs under the rules of the APMS contracts.

It is not currently known whether prior authorisation was sought or given for the change from Ltd to LLP. If this didn't happen then, the campaigners note, it is "a serious breach under paragraph 63 of the APMS contract."

"The letter questions the involvement of NHS England in the process and the campaigners want the investigation to... establish whether any improper influence or control was exerted"

Finally, the letter questions the involvement of NHS England in the process and the campaigners want the investigation to look at the "role, advice and instructions of and on behalf of NHSE in relation to the CCGs", and establish whether any "improper influence or control was exerted."

Bringing subsidiaries together

AT Medics' new owner, Operose Health was formed in January 2020, when Centene Corporation brought together its subsidiaries in the UK – The Practice Group (TPG) and Simplify Health. The Practice Group, which had a number of GP surgery contracts, was acquired by Centene in 2017. Operose's direct parent company in the UK is MH Services International (UK) Ltd.

The takeover of AT Medics was finalised 10 February 2021, when the directors of AT Medics Limited resigned and were replaced by Samantha Jones (CEO of Operose and ex-head of NHS England's new care models programme), Nick Harding (Director of Operose and formerly Senior Medical Advisor to NHS England for Integrated Care Systems and Right Care) and Edward McKensie-Boyle, Chief Financial Officer of Operose.

Operose Health adds the AT Medics' 49 London GP surgeries to its 20 GP surgeries and one urgent treatment centre in Birmingham. In addition, the company lists on its website ten ophthalmology services and a single dermatology clinic in Kent.

Six of AT Medics' APMS contracts are relatively newly acquired, won in early 2020 when it successfully bid on lots in the contract "PRJ736 — London APMS GP Contracts". Each APMS contract runs for 15 years and the six are worth a total of just over £121m. The US corporation Centene has over 30,000 employees in the US and operates health insurance plans for around 2.9 million people in 24 US states. The company acts as an intermediary with Medicare, Medicaid, and The Health Insurance Marketplace System, as well as traditional commercial insurance. In early 2020, Centene took a large stake in Circle Health, the UK's largest provider of private hospitals.

Sylvia Davidson

Can campaigners unite to fight the forthcoming NHS Bill?

AN EXCELLENT CONFERENCE on The Pandemic and Privatisation brought together nearly 500 campaigners last month to think about how to combat further outsourcing and privatisation in the NHS. Details are available here.

Expert speakers set out the most recent evidence of how outsourcing has led to worse services and fragmentation and stood as an obvious obstruction to the need to integrate care services. The phoney value of the private sector healthcare providers was explained.

The disgrace of tax dodging subcos might be coming to an end after fierce resistance but the threats remained. Poor treatment and conditions for staff outsourced to the private sector are one more symptom of the years of austerity funding forcing NHS organisations to look for cost cutting not service improvements.

Speakers set out how years of evidence demonstrates the failure of outsourcing of clinical services and the nonsense of the attempts to treat our healthcare as a market and to pretend competition leads to improvement when our health is not a commodity.

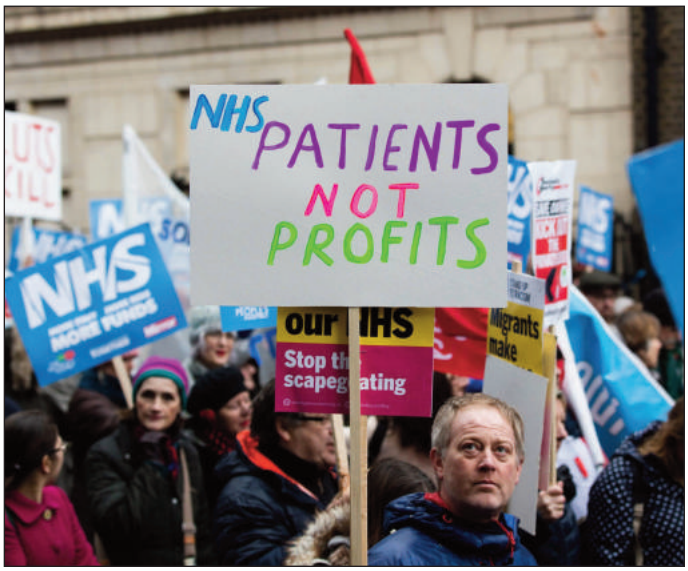
John Lister from Health Campaigns Together shared his 37 years of experience of opposing the outsourcing of government funded services. He suggested campaigning needs better arguments, new lines of attack and new and different campaigns because contracts for new services were being given to private companies without the transfer of NHS staff that has previously focused resistance and solidarity.

John's 10 Ps ("Prohibiting Profiteering Providers and Prioritising Public Provision Prevents Piss Poor Performance") showed his argument that all tools could be valuable including ridicule and sarcasm!

Responding shadow health secretary Jon Ashworth thanked all those who campaign across the country. He pointed out that the government obsession with the illusory superiority of the private sector led to £billions wasted through crony contracting and the elevation of totally unqualified people from private sector backgrounds into key positions.

Public anger at crony contracting is growing and coincides with the emergence of government proposals, backed by NHS England. Allowing private sector providers to influence how funding is allocated and contracts awarded was totally unacceptable.

Other speakers warned that removing the oversight that competitive tendering required might actually lead to more contracts being awarded to friends and family without adequate scrutiny! While the proposals to repeal the worst of the dreadful



Lansley Health and Social Care Act would be an improvement there would still be the possibility of further outsourcing, and no clear plan to reverse previous deals!

A united position in responding to the White Paper and the new Bill will be essential. Key requirements would have to include: investment in NHS capacity to avoid any need or temptation to use private providers to provide NHS funded services – if necessary acquiring private facilities no longer viable; no further framework contracts for private provision of NHS funded acute clinical services other than under emergency provisions; a commitment to reverse existing outsourcing arrangements; return of the complete prohibition of any two-tier workforce arrangements; complete transparency over awarding contracts and an end to any claims of commercial confidentiality to hide business cases, etc; a requirement to prove that the public sector could not provide what is required before any competitive tendering process was considered, and a ban on any outsourcing of public funded services to companies which do not pay their taxes or employ staff on decent terms and conditions; building capacity for the NHS to aggressively manage contracts with private healthcare providers using enforceable penalties for poor performance; enforceable recharging of NHS costs incurred by private provider failures; a clear statement that in any process the NHS is the preferred provider; removal of all conflicts of interest with private providers excluded from any body which allocates public resources or awards contracts.

Richard Bourne

Campaigning for an all-Ireland national health service

CAMPAIGNERS ACROSS IRELAND have begun a fresh drive for a single tax-funded health service covering north and south. Motions in support of this have been passed in the north by three district councils (Derry City and Strabane; Mid-Ulster; and Fermanagh and Omagh). It was narrowly defeated in Belfast City Council by the casting vote of the DUP chairperson.

Similar motions have been passed in Dublin and Sligo in the south, and the Irish Congress of Trade Unions has called for "a public healthcare system free at the point of use, an integrated properly funded health and social care system with a proactive system of public health." The Irish Nurses and Midwives Organisation general secretary Phil Ní Sheaghdha has also lent support.

The earlier Lowdown article (Beware of the Irish Model of Healthcare) has been consistently popular with readers, and the new open letter, reproduced here, is appealing for support from anyone who wants to help campaign for an alternative.

OPEN LETTER: *Covid 19 has highlighted the inadequacy our existing health service. Insufficient hospital bed capacity, too few nurses and healthcare workers, not enough testing and contact tracing, poor regulation in care homes, two separate health services on an island of 6.6 million inhabitants. These are all glaring structural defects, accumulated over decades, that politicians have allowed to continue.*

At the start of Covid, measures were taken which would have been unthinkable.

The Health Service Executive (HSE) budget was expanded by €1 billion and the recruitment embargo on nurses and other key staff lifted. Agreements were secured with private hospitals and hotels – at huge cost to the public purse – to secure extra hospital and step-down bed capacity.

If the extension of the public system was considered necessary then, why not now as the pandemic persists?

Why not provide greater bed capacity permanently in the public system to treat immediately the 800,000 people on wait-

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...continued from page 11

ing lists in the South, and 300,000 in the North?

Why not greater step-down facilities or more home care support?

Why not the permanent extension of state support for GP consultations?

Covid has given glimpses of what a comprehensive public health service could look like, and why we need one.

Throwing public money at the private hospitals to access their bed capacity is not the solution. Nor is buying in private for-profit services in the Health and Care Service in the North.

Private healthcare systems are wasteful and inefficient. Where there are more extensive public health systems - like Belgium or Denmark - state spending on healthcare is 10% of GDP, whereas in the United States where private healthcare is the norm, the equivalent figure is 17%.

In the Republic, the health service consists of a ramshackle, opaque and highly inefficient mixture of public spending from our taxes, private spending from insurance payments and out-of-pocket payments (GP and prescription charges).

The part of the health care sector run by religious orders is categorized as 'not-for-profit', but actually, like the Bon Secours group, it makes huge profits. Even now the Irish Government is gifting our new National Maternity Hospital, at a cost of upwards of €500 million, to a new private entity, 'St Vincent's Holdings CLG', formerly owned by the Sisters of Charity.

Care homes run by the same religious order, in the midst of a pandemic, are being sold off, residents moved on and staff let go. Profit should not drive healthcare any more than patients paying for it should. Healthcare should be a basic social right that everyone is entitled to.

We are calling for all health and social care to be made accountable in a one- tier system, across this island, to which everyone has free access, and which is funded from general taxation and under public control.

The campaign for an All-Ireland National Health Service is based upon the following principles:

Private hospitals requisitioned at the beginning of the crisis should be nationalized

The exclusion of private practice and fees from public hospitals

Permanent public sector-only contracts to be offered to new consultants

Public ownership and control of voluntary hospitals, including the National Maternity Hospital

Reward payments and an enhanced career structure for nurses and health care workers

Publicly- funded Primary Care that includes mental health support, physiotherapy, speech therapy etc.

An integrated Health and Social Care service

A publicly established system to regulate access to and pricing of medicines

To support the campaign send names indicating affiliation (profession, trade union, community group, campaign etc.) to campaignainhs@gmail.com. Twitter @campaignAINHS

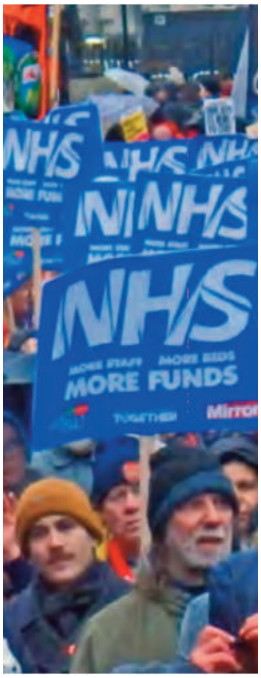
John Lister

DONATE

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.

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