The lowdown

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

US healthcare group buys up London GP surgeries to bolster UK presence

Operose Health Ltd, the UK arm of the large US healthcare insurance provider Centene Corporation, is to take over AT Medics, one of the leading providers of primary care services in London. The Lowdown understands that the details of the change of ownership will be presented to all PCCCs (Primary Care Commissioning Committees) across London over the next week.

AT Medics operates 49 GP surgeries across London, providing services to around 370,000 people, with 900 employees, which until the takeover was owned by six GP directors.

Its 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. TPG, 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.

This latest acquisition is a further sign of Centene Corpo-

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ration taking an expanding interest in the UK health market. The corporation took a major shareholding in Circle Health around the time the latter company acquired BMI Healthcare, the UK's leading private hospital group.

In January 2020 Centene Corporation loaned its subsidiary, MH Services International Holdings (UK) Ltd, the funds for an investment in Circle Health Holdings, although it is clear that Centene already had some level of investment in the company. The additional investment gives MH Services International (UK) Ltd a total voting interest of 40 per cent in Circle Health Holdings. The accounts of MH Services International Holdings (UK) Ltd note that the investment gives Centene significant influence, but not control over Circle Health.

According to the Operose Health website, in December 2020 the company had contracts for 20 GP surgeries, plus one urgent treatment centre in Birmingham. In addition, the company lists ten ophthalmology services and a single dermatology clinic in Kent. These are all services originally run by TPG.

AT Medics is a significant addition to its portfolio as it has won multiple contracts to run GP services across London. Most recently, in February 2020, when the company was the most successful bidder on the "PRJ736 — London APMS GP Contracts" contract, winning six of the 15 lots on offer, contracts running for 15 years and worth a total of just over £121m.

AT Medics will have had to apply to each clinical commissioning group (CCG) where it has a surgery to request a change of control. Under the terms of APMS contracts, contractors are required to seek prior authorisation for any change in ownership and it is possible that the CCG could make any authorisation of a change subject to conditions.

Sylvia Davidson and Paul Evans

New NHS White Paper – does it mean the end of outsourcing?

A leaked version of the new NHS White Paper has confirmed the government's plan to remove the much-criticised competition rules, which allow commercial companies to bid for a vast array of NHS contracts and were a keystone of the Tory health reforms of 2012.

Commenting on the leak, Jeremy Hunt – who was health secretary for much of the time the policy was in place – was shameless in his agreement that scrapping the rules "is the right change", admitting that the policy had caused fragmentation. But the private sector now has a strong foothold in the NHS, so what difference will the change make to the scale of NHS outsourcing?

In the short term the answer is not much. Of course it is to be welcomed that the NHS will no longer have to waste time and money on this bureaucratic whirligig, but the reality is that the private sector has already won £20bn in contracts throughout the competition era, according to figures from the NHS Support Federation, and there is no sign of these contracts being transferred back into the NHS.

For this to happen would need extra investment to fill the gaping hole in NHS capacity. The NHS is 90,000 short on staff at the last count, but predicted to need 250,000 more by 2030.

Hand in hand with the policy to encourage more deals with the private sector was a cynical government squeeze on NHS funding. Recent uplifts in health spending are welcome but not enough – short on staff and dealing with a vast backlog in repairs,

the NHS is ill prepared to cope with the post covid surge so support will be needed if it is to take back commercial contracts.

The Royal College of Surgeons points to the scale of private sector involvement in some areas, stating that a third of all hip operations and a quarter of knee replacements are performed by outside providers.

Figures from the Independent Healthcare Provider Network, which represents non-NHS health organisations, say that in 2018,

21 per cent of all gastroenterology, trauma and orthopedic NHS patients were treated by independent providers (both private and not-for-profit). More than 500,000 non-urgent operations and surgical procedures were carried out by private clinicians for the NHS, about 6 per cent of the total, but these numbers are set to soar.

The NHS is on the verge of signing a four-year deal with private hospitals to help it confront a waiting list that estimates say could soon reach 10m. While we must find care for all NHS patients, this deal should be examined carefully, as it has the look of a more long-standing arrangement, and should not deprive the NHS of the properly funded 10-year workforce plan that surely must be a priority.

The pandemic has heaped more pressure on struggling mental health services, but here too the NHS will be heavily reliant on the private sector. Already, 44 per cent of the spending on child and adolescent mental health goes to private providers. Commercial domination is most complete in the provision of controversial 'locked ward rehabilitation', in which a massive 97 per cent of a £304m market in 2015 was held by private companies.

NHS already heavily reliant on private sector

In local terms NHS commissioners have signed contracts with private companies and charities to provide a range of home care, nursing and community healthcare. On average they spend 15 per cent of their health care budget on non-NHS providers, however there are a group of 18 clinical commissioning groups who spend over 20 per cent.

The pandemic has also already seen a massive rise in public investment in the private sector. The budget for 'test and trace' is now £20bn and has funded the building of the privately driven Lighthouse labs, bypassing the existing network of NHS labs. Health secretary Matt Hancock has already indicated that the Lighthouse facilities will form the hubs for the country's future diagnostic network – so permanently resting it in private hands then?

Certainly, some private health providers were financially revived by their new 'support role' for the NHS. and the commercial sector, like the health secretary, is keen for this relationship to continue.

Talking about the prospect of new legislation David Hare, CEO of the Independent Healthcare Provider Network, said, "It's vital that these new systems build on the partnership working that has taken place during the pandemic."

So the removal of the flawed competition rules is a welcome shift and some reward for years of public campaigning but it does not yet translate into full protection for NHS services from privatisation, or mean that ministers are fully backing a plan to raise NHS capacity so that it can handle demand and take back control of the supply of public healthcare.

See pages 9-10 for more analysis on the White Paper

The Pandemic and Privatisation – how to fight back –

A public conference 25 February

The vaccination programme promises an eventual end to the Covid pandemic, but not before huge contracts have been awarded, that are already exhibiting multiple failures, huge waste and a total lack of accountability, and will inflict long term damage on the NHS.

Speakers at this online event include shadow health secretary Jonathon Ashworth MP.

You can attend for free, access briefing sheets to share and take part in group discussions about the way forward.

Find out more and sign up

- The pandemic has been a goldmine for private contractors and management consultants.
- Billions have been signed away in questionable contracts with no scrutiny or accountability.
- Such huge sums that could have been wisely spent on expanding and adapting NHS services and public health networks as assets for the future were instead frittered away on failed contracts with Serco, Sitel, Deloitte.

Parallel private systems have been set up, that do not properly connect with GP and hospital services, including 'lighthouse' laboratories for testing and processing tests

The question is how health unions and campaigners can work together and develop the right publicity and information to show the folly and expose the waste and inefficiency of privatisation and outsourcing?

Join us for an online conference on 25 February, called by **Health Campaigns Together**, working in partnership with the health unions UNISON, Unite and GMB, the PDA union, the TUC, NHS Support Federation (NHS For Sale), Keep Our NHS Public and The Lowdown.

Covid contracts: transparently in need of scrutiny

Transparency in public office is essential to any democracy, but the UK government's aversion to scrutiny of its procurement track record during the pandemic – an aversion now the focus of judicial and legislative challenges – offers a hint of what may lie ahead for a health service battling almost constant political interference while grappling with underfunding, staff shortages and a life-threatening virus..

One of those challenges – a judicial review (requested by the Good Law Project [GLP], alongside a group of three cross-party MPs) of the government's failure to disclose details of £4bn-worth of pandemic-related contracts – was the subject of a hearing at the Administrative Court *(pictured above)* last Thursday.

The case began last October, when it was revealed that the Department of Health & Social Care (DHSC) had spent £17bn on covid-related goods and services over the previous six months, but contract details for just £12.4bn had so far been made available to the public, in contravention of legal requirements as well as government guidance.

As part of its case, in November GLP said that the average time the DHSC took to come clean about unpublished contracts was, at that stage, 78 days.

At last week's culmination of the review, GLP director Jolyon Maugham noted the government failed to deny it had breached its obligations on transparency, but it had still spent more than £200,000 of taxpayers' money on nine solicitors and five barristers to prepare for a one-day hearing that featured just one witness, along with an unconvincing claim that GLP lacked the legal 'standing' to question the DHSC.

A formal ruling on this case should be delivered shortly.

GLP's justification for pursuing its judicial review was bolstered by publication of a damning report by the National Audit Office (NAO) in November. This report revealed that, under emergency legislation, contracts worth £10.5bn had been awarded directly to companies with no open competitive procedure. Follow-up research from the Institute for Government, released only last week, showed that 99 per cent of covid-19-related contracts have been awarded with no competition.

The NAO also found guidance on transparency wasn't always followed, contracts had been awarded weeks after work had started, documentation was often missing in relation to the 'high-priority' channel for companies with political connections), and much of the PPE ordered was useless or yet-to-be delivered.

Despite the seriousness of these revelations, they seem to have made little impact on the government's conduct.

In December, following the NAO report's publication, DHSC minister Lord Bethell simply refused to name companies who had won contracts via the high-priority channel, claiming there were "associated commercial implications".

Putting those "implications" in perspective, Byline Times has helpfully just published research hinting at the extent of this 'chumocracy', showing the government has awarded covid-related contracts worth more than £880m – 5 per cent of the total expenditure to date on private sector contracts – to individuals and companies who have donated £8.2m to the Conservative Party.

Tory majority restricting the role of MPs

Parliamentary scrutiny of the government's record has inevitably suffered while many MPs have been attending remotely, but Scottish National Party MP Owen Thompson, clearly outraged by the lack of transparency on display, last week presented a 'crony bill' in the House of Commons. His Ministerial Interests (Emergency Powers) Bill aims to ensure MPs can question ministers about personal, political or financial links they may have to companies that have won pandemic-related contracts.

But even though it received the assent of MPs present in the chamber, and will therefore be the subject of a formal parliamentary debate and vote at some stage, the Bill is unlikely to

make it onto the statute books given the government's 80-seat majority in the House of Commons.

So it looks like the only time MPs may have been able to seriously debate the NAO report in any detail was on the morning of 9 December in Westminster Hall, albeit for barely 90 minutes, when the government's performance was defended by junior minister Julia Lopez, the parliamentary secretary at the Cabinet Office, rather than Boris Johnson or Matt Hancock.

And Brexit is only set to make the procurement and transparency picture worse.

Building back better?

Although The Kings Fund last month assessed that the immediate implications of leaving the EU for competition law and public procurement were minimal, and potentially outweighed by the roll-out of NHS England's Integrated Care Systems plan, the thinktank was a little more circumspect on the fallout for the UK's health service from future bilateral trade deals – and with good reason.

The House of Lords had responsibly inserted a clause into the government's trade bill in January banning any agreement with other countries that "undermines or restricts" the UK's ability to provide "a comprehensive publicly funded health service free at the point of delivery".

But, unsurprisingly, no Tory MPs backed the motion, so the amendment was defeated. Trade minister Greg Hands blithely said there was no need to protect the health service with legislation because "the NHS is not and never will be for sale".

At the beginning of February, GLP initiated another judicial review, this time over what it sees as the misuse of Henry VIII powers by the government, potentially enabling ministers to rewrite any law previously touched on by the EU – legislation relating to the state aid regime, for example, which could have a major impact on publicly-financed bodies like the NHS – without parliamentary debate.

Announcing the move last week, GLP said, "With, as we understand it, no state aid regime in place, without the checks and controls it brings, the door is flung open for government to provide financial aid that would favour particular industries and companies... Given the government's tendency to benefit donors to the Conservative Party you may well think we need those rules."

Despite facing accusations of cronyism and a lack of transparency when it comes to pandemic-related procurement, the government's commitment to openness remains paper-thin.

When the Cabinet Office unveiled its 'Transforming public procurement' green paper in December, outlining "long-planned changes to [the] UK's procurement rules", references to transparency in the accompanying press release were easily outnumbered by phrases such as "more flexibility for buyers", "cutting red tape", "reducing bureaucracy" and offering "less burden on business".

And it remains to be seen whether plans revealed last week by news site Health Policy Insight – to reverse the reforms introduced in the 2012 Health and Social Care Act – will genuinely see an end to competitive tendering and outsourcing in the NHS.

These plans appear to represent something of a power grab for health secretary Matt Hancock – affording him the power to transfer functions from one 'arms-length body' to another, effectively strengthening his powers of intervention and eroding NHS England's independence in the process – without needing to bring full legislation to the House of Commons. Hardly a recipe for openness and transparency.

Last week, meanwhile, Information Commissioner Elizabeth Denham sought to address the hollow defence of 'commercial confidentiality' frequently used by government figures when refusing to reveal contract details. She said private companies profiting from pandemic-related work should be subject to the requirements of the Freedom of Information Act, so that journalists and campaigners can scrutinise taxpayer-funded contracts – an idea enthusiastically adopted this week by the Labour Party as part of its new 'insourcing' campaign to bring back public services under democratic control.

An excellent development, especially as the government has so far refused to engage with the idea of an immediate public inquiry into its handling of pandemic-related procurement, frequently suggesting there will be ample time in future years for that to take place.

Petitions being restricted

One potential avenue for those seeking to pressure ministers to allow such an inquiry would be a petition, but debates scheduled by the House of Commons' Petitions Committee – ie those which have more than 100,000 signatures – have had to be postponed because sittings in Westminster Hall, where the debates take place, are currently suspended.

The chair of the committee, Catherine McKinnell MP, called on the government last month to urgently make plans to restart petitions debates, but at the time of writing there has been no published response to her request. Consequently, a current petition demanding a public inquiry into government contracts granted during the pandemic – which has garnered 117,938 signatures (as of 6 February) and waited 89 days for a debate – will not be heard any time soon.

Let's hope the ruling on GLP's judicial review last week goes in its favour, and leads to greater scrutiny of this government's actions during the pandemic. It's essential for our democracy.

Martin Shelley

Private health and privatisation cost lives

John Lister looks at three recent studies that prove what many of us believed to be the case:

The covid-19 pandemic, with its grim death toll and its disproportionate impact on the poorest and most vulnerable, has triggered a fresh round of analysis of healthcare systems and in particular the impact of privatisation and private payments on access to and effectiveness of healthcare.

As the author of a book on the topic in 2013 (Global Health versus Private Profit, available online) I was not surprised, but encouraged by the more recent research which has come to similar conclusions.

It turns out that all over the world privatisation and private healthcare are not only inefficient, expensive and exclusive of those most needing healthcare – they actually result in distorted systems that help spread covid-19 and kill people who might have survived if publicly-financed and -provided healthcare had been available.

UNDP puts a figure on increased death toll

Last May, as most countries experienced the first peaks of the virus, the United Nations Development Project (UNDP) and its Human Development Report Office published an important but low-profile report entitled Privatisation and Pandemic: A cross-country analysis of Covid-19 rates and healthcare financing structures.

It looked at data from 147 countries and found that, "Controlling for per capita income, health inequality and several other control variables, we find that a 10 per cent increase in private health expenditure relates to a 4.3 per cent increase in covid-19 cases and a 4.9 per cent increase in covid-19-related mortality."

This not only applies to poorer countries, but also helps explain why the US with its private healthcare system had "nearly double the mortality rate" of Canada with that country's publicly financed healthcare.

And while globalisation tends to increase the prevalence of covid-19, "higher hospital capacity (in beds per 1,000 people) is significant in lowering covid-19 mortality".

The study also stresses the links between inequality and higher risk of covid-19 mortality, noting that (as we have seen in England), "Poorer people are more likely to suffer from chronic conditions and thus be at higher risk of covid-19 mortality. Poorer people without medical insurance or the means to pay private health care fees may also disregard social distancing in order to keep working …"

The UNDP researchers conclude, "This paper adds to a literature that questions the ability of privately-financed healthcare systems to cope with the scope and magnitude of infectious diseases, including COVID-19."

But they go further, and argue for a fresh evaluation of the impact of neoliberal policies (scaling back public provision and prioritising the private sector) favoured in many wealthier countries, and imposed by them and global bodies such as the World Bank on the poorest:

"Our findings suggest that, to make health systems sustainable at various levels of development and given the expectation of worsening environmental conditions, there is an urgent need to reconsider the neoliberal impulse to privatize health care systems.

"The short-term benefits from such privatization policies - e.g. reduced costs, shorter waiting times - must be weighed against the long-term damage such policies can do to countries' ability to cope with a rapidly-spreading infectious disease."

Private failure in poorer countries

More recent research echoing similar findings has emerged in 2021. Global Public Health last month published a wide-ranging study "The failure of private health services: covid-19 induced crises in low- and middle-income country (LMIC) health systems". The authors, from Leeds and Hong Kong universities, note from the beginning that:

"This paper argues that the catastrophe in privately provided personal health services that has unfolded is not an unexpected outcome of the pandemic, but rather a set of events and outcomes that could have been predicted due to existence of underlying market and redistributive failures that had been embedded in mixed public-private health systems over decades.

"While market failures in private healthcare have long existed and have been well documented, this article explores the ways in which these failures have been thrown into sharp relief by the covid-19 pandemic."

The study draws on a wide search and analysis of 870 newspaper reports around the world, and draws from this data a "triple crisis" of the private care sector during the pandemic: "A financial and liquidity crisis among private providers, a crisis of service provision and pricing, and an attendant crisis in state-provider relations."

The authors argue, "Systems that were already failing to

serve many people and that had not been properly integrated into national health systems were those most poised to fail."

The financial crisis hits in varying ways. The paper notes that especially in low- and middle-income countries the private health sector tends to be less affordable or available to poorer people, and to offer a relatively narrow range of highly specialised elective services for the minority of higher-income or insured people.

In India, South Africa, Turkey and Nigeria a two-tier system has emerged in which "big multi-site chains" dominate a large share of the private market, while beneath them lie smaller private clinics and hospitals.

In some countries (India, Thailand, Brazil, Mexico, Turkey, Costa Rica, Malaysia, Ecuador) sophisticated private hospitals have developed to cater not for domestic demand but for health tourism: these have been hard hit by covid-linked restrictions on travel.

Meanwhile private hospitals dependent on health insurance have been hit by delays or refusals to pay up in Kenya and Lebanon, and government limits in Nigeria, Iraq and Iran. In the US "43m citizens were thought to have lost private employment-linked insurance coverage," while "Indian insurers are publicly stating their model is not up to the demands of a pandemic."

Some private sector providers are "triaging patients on their ability to pay", jacking up prices throughout India with charges of up to $1,000 per day for beds with ventilators, other hospitals demanding advance payments of up to $6,500, and one Zimbabwe hospital charging $5,000 up-front deposit for admission.

In South Africa, where the big three private hospital chains cover just 27 per cent of the population but control 80 per cent of hospital beds and 90 per cent of admissions, the government last June agreed to pay up to $950 per day, per patient. In impoverished Peru the government agreed to pay $15,000 per covid patient.

Meanwhile in Bangladesh, Oman, Iran, Brazil, Philippines, Egypt, South Africa and Pakistan private hospitals are simply refusing to admit or treat covid-19 patients. In Nigeria private hospitals have not been permitted to treat covid-19 patients because they lack adequate infection control.

The paper presents a consistent picture of a grasping, unethical and dishonest private sector gouging profits and gaming the system at the point of greatest need for healthcare – with no regard for the health of the poorest. Its concluding section notes what should happen:

"If the private sector emerges intact financially from the pandemic, it should expect to encounter much more opposition from

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civil society and health workforces to its role in healthcare, with regulatory push back from governments and far tighter controls on market entry and competition.

"Given the data we presented above, the role of the private sector in the delivery of health services should be reconsidered, and the regulation of this sector should be further strengthened."

However it warns of the political and economic forces limiting the extent to which the system can be corrected, not least because it's likely the World Bank and the IMF "will continue to favour the private sector and market-based delivery of health."

European privatisation

Closer to home, another weighty institution that has embraced neoliberal policies (largely at the behest of previous British governments since Margaret Thatcher was prime minister) has been the European Union.

Another new report, When the Market Becomes Deadly from the Corporate Europe Observatory, paints what might be a rather more familiar picture of the impact of four decades of policy since Thatcher and US president Ronald Reagan helped impose neoliberalism as the predominant ideology in the developed world.

However the underlying message in Europe is the same as in the lower-income countries: privatisation kills. "Analysis shows healthcare privatisation has reduced countries' long-term preparedness for dealing with pandemics."

Throughout Europe, as we have recently seen exposed in Britain, the private hospital sector is utterly dependent on a sufficient flow of public funds:

"As part of this marketisation, private for-profit providers seek what they call a level-playing field with public providers; in other words, a slice of public funds.

"This is partly because for the private healthcare model to be profitable (beyond just the wealthiest minority of paying clients), it still requires public funding – since often, those most in need of healthcare are least able to pay the 'market price' for it."

The study highlights the role of the European Union of Private Hospitals (UEHP), a lobby group active in Brussels, which argues that the private sector has played an "integral role" in combating covid-19, and that "private hospitals in Europe do not create inequality" – but rather "inequality is created 'by the financing system".

"According to UEHP, inequality only arises if the public sector refuses to pay private hospitals for patients' care, leaving patients to face high out of-pocket payments. And that, it insists, is the fault of public sector gatekeepers, not the private hospitals!

"Thus UEHP argues that it is 'essential that the system treat the private and the public hospitals on an equal basis'." This will be familiar to Lowdown readers who have followed the saga of NHS England's deals with private hospitals.

However while the general lines of the argument – noting the damage done to pandemic preparedness by neoliberal cuts in public spending and hospital bed numbers – and the attack on the evidence-free myths of private medicine are sound, some sections of the study suffer rather badly from pretty use of ancient statistics .This is especially true of the section on Public Private Partnerships (known as PFI in Britain) which has few facts post-2016.

Fortunately this limitation does not apply to a number of useful case studies of Italy and Spain and a full-page box on the pernicious role of McKinsey in "confidential covid-19 work for the [EU] Commission".

The section on long-term care, with a case study from Sweden, and examples from various countries, will also be grimly familiar to campaigners up against the chaotically privatised social care system in England, and the death toll since the pandemic struck.

The pamphlet concludes with a simple summary: "To strengthen health systems in Europe, the EU should terminate neoliberal policies that have resulted in damaging budget cuts and created pressures to privatise and commercialise healthcare and elderly care systems, thereby weakening Europe's pandemic preparedness."

Specifically the demands are that the EU should:

"End austerity, starting with a commitment not to return to pre-covid-19 austerity rules, including the Fiscal Compact.

"Remove the pressures towards liberalisation, commercialisation, and privatisation that undermine public healthcare systems and the welfare state more generally.

"Ensure that covid-19 recovery funds are used to strengthen public hospitals and healthcare provision, rather than for-profit, private hospitals.

"Protect public services from being further prised open by the EU's trade and investment agenda."

World Health Day of Action

On 7 April (World Health Day), British campaigners can help challenge this logic by joining the Day of Action for #Health4All, coordinated by the European Network Against the Commercialisation and Privatisation of Health and Social Protection.

The day of action will focus on the four demands of the European Citizens Initiative and the demand to invest more in healthcare and health workers. There will be decentralised actions throughout Europe.

White Paper: power grab, sea change, or cementing in the status quo?

Some of the headlines and reports on the leaked draft White Paper outlining plans for a new top-down reorganisation of the NHS are quite remarkable. The Times and the BBC, clearly following a steer from Downing Street both heralded the plans as a step to "scrap forced privatisation and competition within the NHS".

In the Daily Telegraph an article by Theresa May's former chief of staff Nick Timothy also proclaims a sea-change in government policy, headlined "Covid exposed the folly of turning the NHS into an unaccountable quango" – and as if that were not enough to have Torygraph readers spluttering over their porridge, a sub-headline apparently questioning Margaret Thatcher's political legacy: "Years of market-based reforms have ended up increasing bureaucracy, waste and inefficiency."

There seems to be a consensus among the media reports that the new draft represents a substantial shift of policy: but is this really the case? Sometimes the real clues to a statement lie in what is left out rather than the words it uses. Most of the 40 pages of the leaked draft are giving retrospective recognition and legal status to a fait accompli.

Much of Lansley's legacy will remain

The mainstream media reports highlight new powers for the Secretary of State to intervene in and 'take back control' over – and responsibility for – the NHS, which were technically sacrificed in Andrew Lansley's *(pictured above right)* disastrous Health and Social Care Act in 2012. They all agree that the proposals would move decisively away from the fragmentation and competition entrenched in Lansley's Act to a new focus on collaboration and "integration".

However ,while key sections of the Act are already being publicly flouted, much of it would remain in place.

NHS England (NHSE) is already three quarters of the way through its plan to force through mergers of the local clinical commissioning groups (CCGs) set up under the Act, to lay the basis for just 42 Integrated Care Systems (ICSs) which it aims to put in charge.

The remaining 13 areas have been told to complete their CCG mergers by April, or face intervention, despite grumbling from

Leeds CCG chiefs and warnings from one of the pioneer ICSs, Bedford Luton and Milton Keynes, that the new set-up is far from the promised smoothly integrated system, and little more than a fractious stooge body following NHSE's every whim.

And while the latest reports allude darkly to ministers' "frustration" at the "independence" of NHSE boss Simon Stevens, there are no clear examples of what ministers have wanted to do that has not been done. Successive health secretaries Jeremy Hunt and Matt Hancock have repeatedly responded as if they were still in full charge of the NHS.

Giving the health secretary back powers to intervene earlier in controversial hospital closure plans and reconfigurations simply highlights the failure of Hunt or Hancock to block half-baked schemes – such as Shropshire, Huddersfield, and South West London – that have been referred to them by disgruntled local councils. However the linked proposal to remove council's right to refer contentious schemes to the Secretary of State would remove the last remnants of local accountability on plans which lack public support – and is likely to incur the opposition of council leaders.

It's when it comes to the issue of contracting and the private sector that the silences and omissions shout louder than the weasel words in the leaked draft.

It's clear that a government that has looked first to private contractors and consultants for test and trace, laboratory services and procurement of PPE, and is planning to spend up to £10bn on private hospital care for the next four years rather than invest in the NHS is not by any means calling time on privatisation.

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There is no plan to scrap the historic Kenneth Clarke/ Margaret Thatcher division of England's NHS into a "market" separating purchasers (commissioners) from providers, and as experience in Bedford Luton and Milton Keynes shows, these divisions are still alive and well in "integrated" care systems.

There is no plan to roll back contracted-out clinical or support services – or even a commitment to bring these back in-house as contracts end.

Nick Timothy points out that the end of the fixed-tariff payment system for clinical services could actually result in more privatisation – allowing private hospitals to under-cut NHS trusts, and cherry pick low-cost simple elective cases, leaving the NHS saddled with more complex cases.

Removing the requirement for competitive tendering on contracts is also rather more contentious now we have had 12 months in which contracts worth billions awarded without competition for supply of PPE have yielded questionable results and triggered widespread complaints of cronyism – and criticism from the National Audit Office.

Accountability upwards or downwards for ICSs?

Significantly, the new rules that will offer ICSs discretion on whether or not to put contracts out to tender do not apply to "professional services" – effectively exempting the gamut of number-crunching back-office services needed to deliver the Long Term Plan's focus on "digital" systems and "population health management". The draft makes no mention of the £700m Health System Support Framework already established by NHSE to fast-track the outsourcing of such contracts to a pre-approved list of over 80 mainly private companies, more than a quarter of them US-owned.

Meanwhile there is an eloquent silence on whether the statutory ICSs would be accountable downwards to local communities as well as upwards to NHSE and ministers, and no promise they would meet in public or publish board papers.

While there will be "a duty placed on the ICS NHS Board to meet the system financial objectives which require financial balance to be delivered," there seems to be no provision to ensure an ICS allocates the "single pot" of funding for the health system fairly and with regard to health inequalities – or what would be done if they failed to do so.

Strangely, the leaked proposals would not even integrate the leadership of ICSs: while there are new powers to curb capital spending by foundation trusts, not only do NHS trusts and foundation trusts "remain separate statutory bodies with their functions and duties broadly as they are," but each ICS would require two boards.

The main ICS Board, with commissioning powers, would include NHS 'partners' and local government. The second, subordinate, ICS Health Partnership would effectively act as an enlarged Health and Wellbeing Board, also involving local government, alongside voluntary sector and, notably, private ("independent") providers. This is admitted to be a concession to complaints from the Local Government Association that councils were being left on the sidelines of ICSs – but in practice institutionalises the subordinate role of local government.

A 'dead cat' move

There is little discussion of the role of GPs in the new set-up: they were (falsely) claimed to be put "in the driving seat" when CCGs were established in the 2012 Act, but they would have even less influence in the new ICS bodies covering much wider areas and dominated by the big acute hospital trusts. There are only fleeting references to mental health, which would also be further marginalised by the proposals.

There is much more in the draft – but nothing to explain the biggest riddle of all: why ministers have decided now is the time, in the middle of a pandemic, to focus on another reorganisation of the NHS.

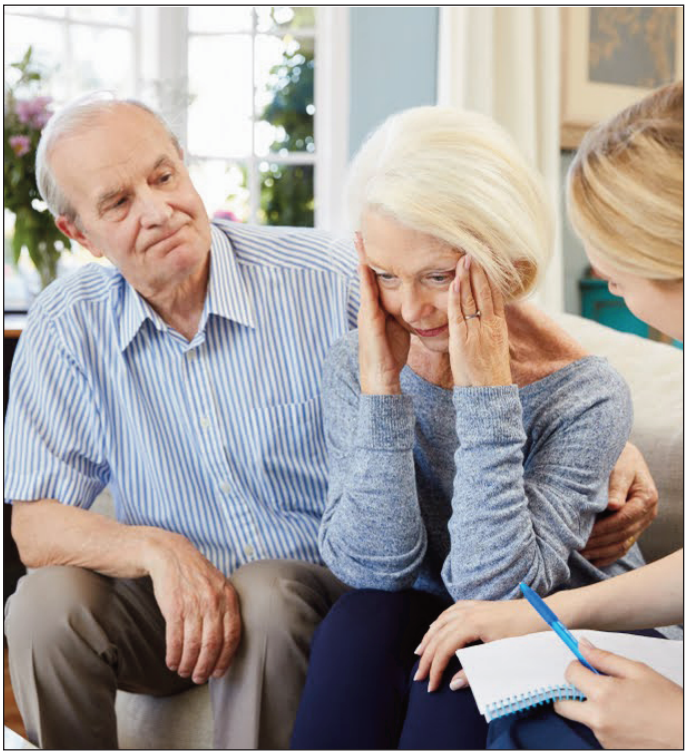
If ministers simply wanted to scrap the requirement to put contracts out to tender they could do so at any point by simply revoking the regulations that followed the 2012 Act.

So why now? Are they finally giving way to pressure from NHSE to ditch some of the broken structures of the 2012 Act? Or is this maybe a convenient 'dead cat' to divert attention and discussion from the urgent need for a big increase in NHS revenue and capital funding as we run up to the March budget?

Funding, including the dire shortage of capital as the NHS maintenance backlog has soared to £9bn, is the other missing link in the draft. No matter what reorganisation the White Paper finally ushers in, after a decade of real-terms cuts and austerity, the NHS cannot go forward and cope without an extra injection of cash.

John Lister

Mental health sector still waiting on promised improvements



As we move into 2021, the year Jeremy Hunt promised to have redressed the "historic imbalance" between physical and mental health, and ended the scandal of patients being treated miles from home, it's already clear that none of Hunt's promises made back in 2017, when he was still health secretary, were worth the paper they were printed on.

Hunt committed to an extra 21,000 new posts, treating an extra million patients a year to help deliver prime minister Theresa May's promised "revolution" in mental health. But now Hunt, May and their promises have all been overtaken by history.

The 21,000 extra staff were to include "an additional 4,600 specially trained nurses working in crisis centres". In fact the mental health nursing workforce has increased by just over 3,000 (8 per cent) since the pledge was made, and few of the other promised extra staff are anywhere to be found.

At the end of January the Royal College of Psychiatrists once more issued a grimly familiar warning that mental health trusts are still struggling on with too few beds, too few staff and too little funding.

And 85 per cent of the 320 psychiatrists who responded to the survey last December said there was more pressure on beds than a year earlier – and 92 per cent estimated that they had fewer than 5 per cent of beds available for urgent admissions. More than a third said they would look for beds outside their area and a quarter said they would delay admission and treat patients in the community.

RCP President Dr Adrian James said, "The historic problem of shameful mental health bed shortages that the government pledged to end in 2021 is only getting worse.

"More and more people are in mental health crisis as a result of the pandemic, and instead of being able to treat them, psychiatrists are forced to send them miles from home or ask them to wait for months on end to get help."

More funds needed to bridge a gap in care

The Royal College of Psychiatrists is calling for an extra £150m funding in 2021/22 to 'bridge the gap' between inpatient care and community support, to facilitate more timely and effective discharges. But the college is also asking the government to invest in additional beds that are properly staffed and resourced in high priority areas – and to commit to build a further six mental health hospitals by 2024/25.

Last autumn the Health Foundation went further, noting that: "Over the next three years, we project referrals to dedicated mental health services for adults and children could increase by an average of 11 per cent."

On that basis they estimated that meeting this increased demand could require an average annual increase of up £1.4bn per year, over and above existing funding.

Meanwhile the impact of the bed shortage is well illustrated by the efforts by the chief medical officer of the Norfolk & Suffolk NHS Foundation Trust to delay or prevent admissions of seriously ill patients – by issuing a circular requiring that "All admissions for patients who are not under the care of a CMHT [Community Mental Health Team] will require agreement from the consultant responsible for the inpatient ward where admission is proposed."

As the local mental health campaigners (Norfolk & Suffolk Mental Health Crisis) point out, the consultant concerned will almost certainly have beds already full – and have no current knowledge of the patient or their state of health.

But neither will the other consultant who is supposed to take a view. The new guidance states: "The [ward] consultant

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will liaise with the consultant in the patient's 'home' CMHT to establish what treatments or assessments might be required in hospital before agreeing to an admission." But since the patient is NOT under the care of a CMHT, its consultant will have no knowledge of them either.

As the campaigners point out, "This means that two busy consultants will be diverted from their jobs treating patients… to discuss the treatment or assessment which most likely neither of them will be involved in."

This raises a thorny question: can a decision by a patient to agree to an informal admission to avoid a section assessment under the Mental Health Act be overturned by two doctors who have never met them?

Even more alarming, given the recent disastrous experiences of failures of care in this trust: "What will the coroners think if people die having been refused admission by two doctors who have never met the patient overruling mental health professionals who have?"

The whole chaotic situation in the trust arises from the lack of sufficient local beds, compounded by the trust's attempts to save money by closing beds without having put alternative services in place. During 2020 the rolling three- month average number of 'out of trust bed days' (patients dispatched to distant beds for lack of local space) almost trebled, from 350 to more than 900.

The Royal College of Psychiatrists points out that out-of-area placements can harm patients by increasing their distress, separating them from their families and slowing their recovery.

Meanwhile another 2017 promise by Theresa May, to scrap the "flawed" Mental Health Act, as part a drive to revolutionise mental health care, has moved a step closer with the publication in January of a government White Paper on reforming the act, opening up a consultation that ends on 21 April.

However good the proposals, the catch is that reform of the Mental Health Act alone will not be enough to improve mental health services.

Funding needed, as well as new legislation

Responding to this latest move, NHS Providers said, "New legislation is only part of the story… We need to address the underlying issues driving the pressures on services and the rising severity and complexity of people's needs.

"We note the government confirms that reforms will require additional funding and expansion of the workforce, over and above commitments made in the NHS Long Term Plan, and the delivery of the proposals set out in the White Paper will therefore be subject to future funding decisions."

Whether or not this implicit government promise of additional funding and commitment to improve the quality as well as accessibility of services will be worth any more than previous promises remains to be seen.

As patients in Norfolk and Suffolk and many other areas are still finding out the hard way, there is a wide disparity between positive promises and statements and the delivery of actual services on the ground. ***John Lister***

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