Holding back NHS recovery:

A report on the interaction of privatisation, underfunding and the neglect of workforce planning in the UK's public health service

May 2022

KEY POINTS...

... Tackling waiting lists through the independent sector is of limited benefit

... Recovery plans are fundamentally undermined by under-resourcing

... Insufficient capacity building pre-dates the pandemic, harms patient care

... Underfunding facilitates growth in outsourcing, but the private sector relies on public investment in the healthcare workforce too

... Lack of transparency, impact assessment and strategy

... Policy makers fail to act on the evidence about the impact of outsourcing

... Transferring more responsibility to the individual

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NHS SUPPORT FEDERATION

Summary

The interplay between the underfunding of the NHS, the lack of a funded workforce strategy for the NHS and the growing reliance on the private sector to provide clinical services to NHS patients can be seen as part of a single policy approach, which if maintained will impede the crucial growth of NHS capacity. This report looks at how the role of the independent sector is developing alongside the failures to fund and plan NHS services adequately and how the pandemic has brought these issues to a head.

KEY POINTS EXPANDED:

1. Tackling waiting lists through the independent sector is of limited benefit
The scale of the unsatisfied health need in the community is an unprecedented challenge for the NHS. A degree of partnership with the private sector is necessary in order to limit suffering and reduce delays, however the gains from this partnership are limited. The extra elective capacity the independent sector can provide is heavily restricted, not least because most of its consultants also work within the NHS. Its total bed capacity is less than 10% of the NHS and these companies are also compromised by their dual goal of satisfying the demand from private patients.

2. Recovery plans are fundamentally undermined by under-resourcing
The NHS strategy for tackling the growing waiting lists, as expressed in the Delivery Plan is not backed by a funded workforce plan, despite the fact that the Plan recognises the need to lift elective capacity by 30% by the end of 2023/4. A funded workforce plan would help to retain staff in the short term as well as finally start to train sufficient staff for the future. Undermined by underfunding, the Delivery Plan places its focus on cost savings, reform, new technology and a bigger role for the private sector.

3. Insufficient capacity building pre-dates the pandemic and harms patient care
The NHS is not just battling the impact of the pandemic but also the fallout from a decade of under-resourcing and the neglect of key planning on workforce. The reluctance of the government to set out adequate long term investment in NHS staffing, in equipment and for the repair and building of new facilities is impeding the ability of the NHS to achieve improvements in access and the standard of care for its patients. The backlog of repairs of £9.2bn in hospital repairs threatens safe operating and new capital investment is needed in GP and community services. The UK has fewer MRI and CT scanners than comparable countries - further evidence of the longstanding investment shortfall.

4. Underfunding facilitates growth in outsourcing, but the private sector relies upon public investment in the healthcare workforce too
The outsourcing of NHS clinical services tends to expand in sectors of the NHS where there has been a failure to build suffcient capacity and where a financial return can be made. Both diagnostic and mental health services are examples of sectors where the NHS has become highly dependent upon the capacity of private providers to deliver care, and concurrently NHS facilities have been consistently under-resourced and unable to keep up with rises in demand. Ultimately though, underinvestment in NHS training reduces the pipeline of future staff in public and private sectors, as shown by the cutbacks made by companies providing mental health services to the NHS because of staff shortages.

5. Lack of transparency, impact assessment and strategy
During the pandemic the government displayed a preference for solutions based around private sector involvement, particularly in the strategy around the test and trace operation, which bypassed existing NHS labs and the

tracing expertise within public health services. Substantial financial deals have also been struck with private hospitals to secure extra bed capacity for NHS use which have been heavily criticised for their poor value and exposure of the NHS to financial risk.

6. Policy makers fail to act upon the evidence about the impact of outsourcing

As the government steer the NHS through yet another reorganisation it is important to protect against the failures seen in previous contracts with private providers and to examine the impact of outsourcing on the future sustainability of the NHS. National data about outsourced contracts and their performance is scant. The companies themselves are opaque and not fully accountable. There is no obvious process at national policy level to monitor the impact of relationships with private providers across the NHS, despite the wealth of experience and evidence that now exists. Crucial strategic questions include: Can the NHS continue to deliver on its core principles - of comprehensive health to all in a fair and effective way, if the private sector has dominant control of the supply? How effectively are these contracts managed? How is the public interest protected when commercial interests diverge from those of the NHS? Failure to examine these questions is part of the ongoing exposure of the NHS to risk of failure in its core aims.

7. Transferring more responsibility to the individual

As the NHS visibly struggles under the pressure, it is sowing doubt within the public's mind about the ability of the NHS to meet health needs and driving those that can afford it towards the private health sector. Some NHS staff, seeing no prospect of relief from the pressure of work, are leaving their NHS posts. The government must reassure the public and NHS staff by making a long term commitment to invest in increasing the NHS workforce and invest in its infrastructure, and at the same time aim to limit and reduce the reliance upon the independent sector.

Contents

The pandemic's effect on tendering

The Covid-19 pandemic led to the introduction of emergency procurement procedures, under which no competitive tender process had to take place. The vast majority of contracts awarded for products and services related to Covid-19 were awarded under these emergency procedures.

Despite the huge challenge of the time and the achievements in responding to the crisis, investigations have highlighted a long list of issues for public concern, which should resonate loudly in the debate about the methods and justification for outsourcing. And as Parliament considers new laws affecting the procurement processes in the NHS it adds weight to the case for a permanent upgrading in transparency and accountability around these decisions.

Here we summarise the numerous issues around the use of the emergency procurement measures and large-scale private sector involvement during the first two years of the pandemic.

Accusations of cronyism and corruption

Problems in the awarding of Covid-related contract issues were first highlighted by the not-for-profit organisation, The Good Law Project, and several journalists, including from The Guardian and The Times, who asked questions about why some of the companies had been awarded contracts and highlighted their connections to political figures.

In August 2020, The Times reported *(01)* that contracts for PPE worth more than £180m had been awarded to companies owned or run by prominent supporters of the Conservative Party. The investigation identified 12 contracts handed out by the government to three firms with links to Conservative Party donors or members.

Eventually by mid-2020 complaints by opposition MPs and from the public triggered an investigation by the National Audit Office (NAO), covering concerns about bias in the awards process, conflicts of interests, and awards to unsuitable suppliers. Public pressure was rising as the Good Law Project launched legal action to release more information and investigations from journalists revealed more revelations.

NAO reports highlight problems

In November 2020, the NAO published two reports based on an audit of the procurement processes that took place between March and the end of July 2020 - Government Procurement during the COVID-19 pandemic *(02)* and the supply of personal protective equipment (PPE) *(03)* during the COVID-19 pandemic. The reports reveal that of the staggering £17.3 billion of Covid related con-

01 – https://www.thetimes.co.uk/article/1
02 – https://www.nao.org.uk/report/government-procurement-during-the-covid-19-pandemic
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"It was clear that having political connections increased access to contracts, as companies with political connections were ten times more likely to be awarded a contract than companies that did not have such connections, according to the NAO."

tracts awarded, the use of the emergency procedures meant that £10.5 billion worth of these contracts were awarded directly to companies without any open competitive procedure taking place. A further £6.7 billion was awarded to companies that were already listed on framework agreements with the government.

Although couched in less sensational language than many of the media reports, the NAO findings are no less shocking and the reports are highly critical of what took place over those first months of the pandemic. It was clear that having political connections increased access to contracts, as companies with political connections were ten times more likely to be awarded a contract than companies that did not have such connections, according to the NAO.

VIP channel exposed

The NAO reported that the government had split the procurement system into two channels – a high-priority channel, which has become known as the VIP channel, for companies with political connections, such as links with government officials, ministers' offices, MPs and members of the House of Lords, senior NHS staff and other health professionals, and a second channel for those companies without connections to such people.

The NAO found that about one in ten suppliers processed through the high-priority or VIP lane (47 out of 493) obtained contracts compared to less than one in a hundred suppliers that came through the ordinary lane (104 of 14,892). There was a lack of complete documentation surrounding the contract award procedure, but in the cases where documentation was present 144 of the referrals came from the private offices of government ministers, including "referrals from MPs who had gone to ministers with a possible manufacturer in their constituency, and where private individuals had written to the minister or the private office with offers of help".

There were another 64 companies where referral was directly by MPs or members of the House of Lords, and a further 21 were referred by government officials.

Companies in the VIP channel were automatically regarded as more credible, which is in contrast to normal practice when such contacts would be subject to additional scrutiny due to issues of conflict of interest. The NAO also found that there were no written rules for how the VIP channel should operate.

The system seems to have allowed for the awarding of contracts to companies for inexplicable reasons. Companies that have no history of PPE procurement or production were given vast contracts.

Questions were raised about a £108m contract to Pestfix, a tiny pest control company with net assets of £18,000. Another £108m contract went to a modestly sized confectioner in Northern Ireland, Clandeboye Agencies. And another worth £252m, was awarded to Ayanda, an opaque private fund owned through a tax haven. It was hard to find evidence that these companies had any previous experience in supplying PPE.

Ministers use personal emails for government business

To add to the murkiness of the contract awards situation, in June 2021, it was revealed that Matt Hancock *(04)* and James Bethell both used personal email addresses to conduct business, including PPE and related contracts.

04 – https://goodlawproject.org/news/leaked-personal-email/

Number 10 had previously denied that this happened. The Guardian revealed *(05)* that a number of emails were copied into Lord Bethell's private email account, including at least four official exchanges relating to a businessman who was attempting to get government contracts during the pandemic.

Companies in VIP lane leaked

The Good Law Project requested the list of companies that had been recommended by politicians for inclusion on the VIP list. On 18 October 2021, the Information Commissioner *(06)* ordered the Department of Health and Social Care (DHSC) to disclose the names of the 47 companies on the VIP list to the Good Law Project within 35 calendar days.

In November 2021, a leaked document revealed which Conservative MPs and Peers helped to guide companies through the 'VIP lane' towards lucrative PPE contracts. Michael Gove MP, Matt Hancock MP, Esther McVey MP, and Steve Brine MP are among the Conservative politicians *(07)* who referred companies to the VIP lane.

Around £1.6 billion worth of contracts were awarded as a result of referrals from just ten politicians at the heart of the Conservative party. Then in February 2022 The Good Law Project saw documents showing that the VIP lane was much larger than had previously been reported. The new documents added another 18 other companies to the VIP list *(08)*.

The Good Law Project has highlighted *(09)* that although the government claims that the VIP lane for PPE contracts "was widely advertised across Government as a way of more quickly triaging offers of support", the list of companies in the 'VIP lane' shows that no other political party successfully referred companies via this route.

Lack of transparency

The introduction of emergency contracting regulations in early 2020, which meant that no competitive tendering process had to take place, was widely viewed as necessary to respond quickly to the pandemic. The vast majority of contracts awarded for products and services related to Covid-19 were awarded under these emergency procedures. However, no tendering process

05 – https://www.theguardian.com/politics/2021/jun/28/health-minister-helen-whately-used-private-email-for-government-work-matt-hancock
06 – https://goodlawproject.org/news/they-have-to-reveal-the-names/
07 – https://www.theguardian.com/world/2021/nov/16/five-tory-mps-peers-referred-firms-controversial-vip-lanecovid
08 – https://goodlawproject.org/47-companies/
09 – https://goodlawproject.org/news/conservative-politicians-vip-lane/

also meant minimal transparency around which companies were being awarded the contracts and any justification.

What the government appeared to 'forget', however, was that despite the emergency procedures, awards still had to be published within 90 days. The NAO in its November 2020 reports found that over half of the contract awards were not published within the time frame set out in Crown Commercial Service guidance. Of the 1,664 contracts awarded across government up to the end of July 2020 with a contract value above £25,000, 55% had not had their details published by 10 November 2020.

Legal action needed to see contract awards

In October 2020, the Good Law Project (GLP) took the government to court over the delays in publishing the contract award notices. The GLP together with a cross-party group of MPs – Caroline Lucas (Green), Debbie Abrahams (Labour) and Layla Moran (LibDem) – took legal action against the Government for its persistent and unlawful failure to disclose details of Covid-related contracts.

At the start of March 2021, the High Court ruled that the Government had acted unlawfully by failing to publish Covid contracts. The High Court ruled "The Secretary of State acted unlawfully by failing to comply with the Transparency Policy" and that "there is now no dispute that, in a substantial number of cases, the Secretary of State breached his legal obligation to publish Contract Award Notices."

However, just three days later Boris Johnson stood up in the House of Commons and reassured MPs and the public that all Covid-related contracts were "on the record". The final Order handed down by the Judge, however, showed that what the Prime Minister told the House was untrue.

Many issues hindering transparency of contract process

The NAO also found many other issues that hindered the transparency of the contract process. In many cases documentation was missing, covering such things as the justification for using emergency procurement, why particular suppliers were chosen, or how any potential conflicts of interest had been identified and managed. Lack of documentation was much worse in the VIP channel; of the 493 suppliers referred to this channel by a political or official contact, less than 250 had the details of the individual who made the reference recorded in the government's case management system. The NAO also found contracts that had been awarded in retrospect. One example was a contract awarded by the Cabinet Office, a £3.2 million contract to support the cross-government PPE team's procurement of PPE awarded on 21 July 2020, but which ran from 14 March 2020.

Government protects companies in VIP lane

At the time of the NAO reports, the government refused to publish a list of companies that benefited from being put in the 'VIP' lane for Covid-19 contract work or to reveal who were the individuals that recommended the companies be put in that lane.

The Liberal Democrat peer Lord Strasburger asked in the House of Lords whether the government intended to publish "a list of all companies who were contracted to supply PPE as a result of the high-priority lane" and if the name of the person who recommended the company would be published.

The answer from Lord Bethell, a minister in the Department of Health and Social Care (DHSC), was a resounding no, giving the reason for this as commercial implications.

Lord Strasburger told the Guardian that he was not satisfied with the government's reason for its refusal to disclose the names of the companies. He said "It looks to me as if the government doesn't want taxpayers to know which companies were given preferential treatment, often at the expense of more proven competitors. They also don't want us to know which minister or MP was able to slip these companies into the fast lane and what their connection is with the company." Lord Strasburger called for a full independent enquiry into how the contracts were awarded.

Continued use of emergency procedures undermines public trust

Whilst there appears to be some good reasons for using the emergency procedure in March 2020, it was still being used in November 2021. An article in the FT *(10)* in April 2021 noted that there was growing concern that there has not been a return to open competitive tenders, in particular given the NAO reports highlighting that there was a risk that continuing with the emergency procedures would "undermine public trust." In November 2021, the Labour Party questioned why the system was still in place, saying in a letter to the Cabinet Office "that while there had been a reason to introduce the procedures at the peak of the emergency, they brought a risk of conflicts of interest and unsuitable suppliers being used."

10 – https://www.ft.com/content/ca80611a-d020-4f17-ba99-c75350e1bed1?sharetype=blocked

"The NAO highlighted that although the government set up a parallel supply chain procurement process that was designed to enable rapid procurement and processes were supposed to be in place to avoid waste, the parallel chain managed to buy equipment that did not meet the correct specifications, thereby 'wasting hundreds of millions of pounds'."

The use of the emergency procedures meant that the process of awarding the contracts became opaque. The government departments involved, however, still had to publish the final award notice either on the Contracts Finder database or the TED (Tenders Electronic Daily) database, both accessible to the public. Despite these rules, many award notices have not been published yet and are well overdue, others have been published late.

Value for money... PPE

Government lack of preparedness led to paying a high price

In the NAO reports the stockpile of PPE kept before the pandemic was described as "inadequate" as it contained only two weeks' worth of PPE. As the pandemic struck it soon became apparent that far more was needed and the government had to order vast quantities of PPE in a chaotic market with over-inflated prices.

The government was buying gowns and coveralls, which would have cost 33p each in 2019, for £4.50 each, an increase of 1,277%. One million body bags that would have cost £1 each last year were bought for £14.10 each.

The NAO estimated that the government spent £10bn more buying PPE in the inflated market conditions during the pandemic than it would have paid for the same products in 2019. In its 2020/21 accounts, the DHSC had to write down £4.7bn *(11)*, which was the difference between the dramatically inflated prices the DHSC paid for PPE and the value of that equipment now.

The accounts, audited by the National Audit Office, do not identify where that extra £4.7bn was paid. It could have been in increased prices to the PPE factories, mainly in China, or in significant profits made by UK companies and their intermediaries.

Defective and unsuitable PPE bought

Not only did the government overpay for PPE, it also managed to buy millions of pounds worth of defective and unsuitable products. In February 2022, the publication of the DHSC accounts *(12)* showed that tonnes of items bought for £2.6bn were never usable by the NHS and a further £670m worth of PPE was not usable at all in any healthcare setting. This was mostly because it was defective, the annual report stated, and items costing £750m passed their safe date before they could be used.

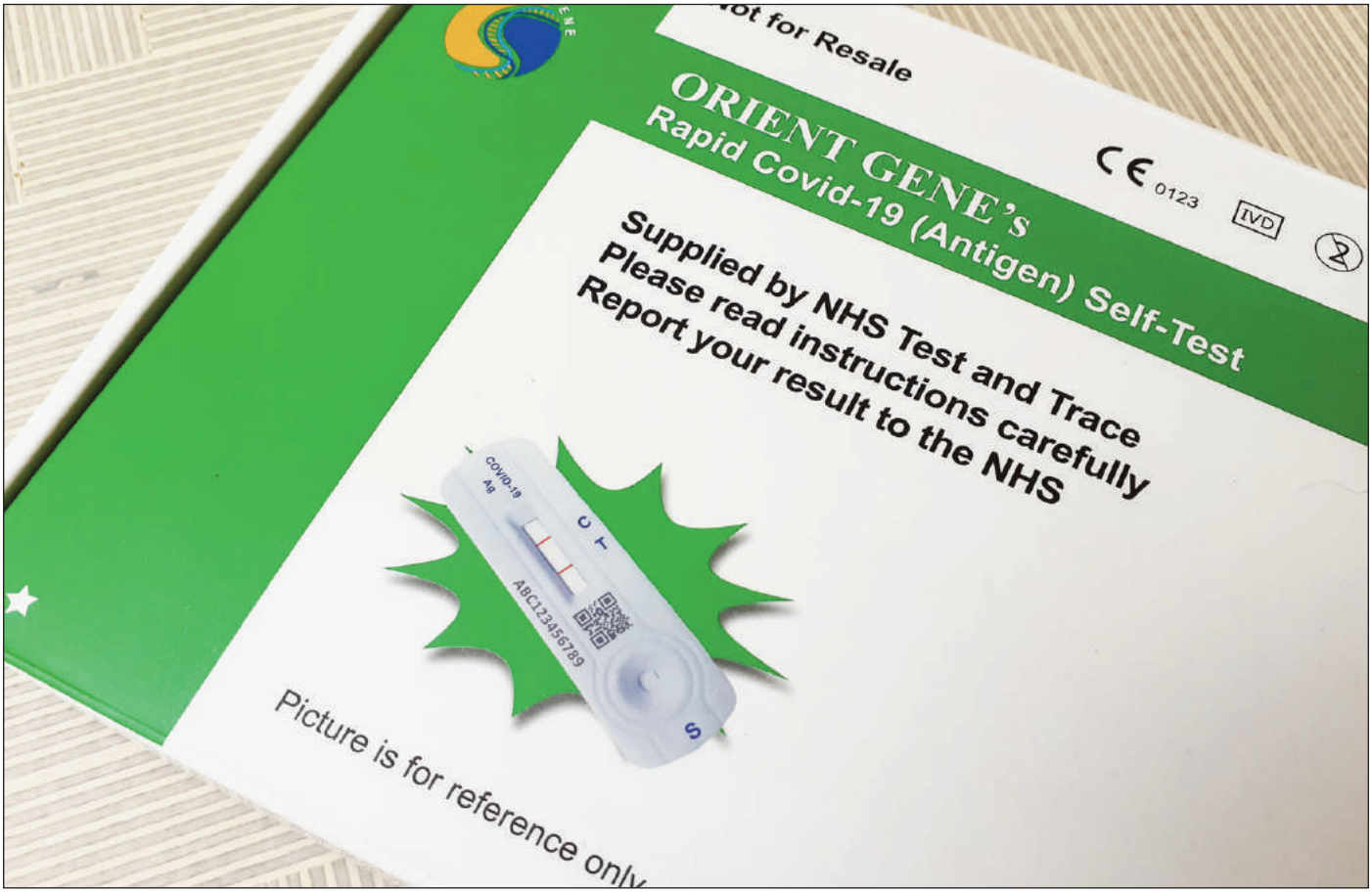
The NAO reports published back in November 2020 had already concluded that millions of pounds had been wasted on PPE that was unusable.

The NAO highlighted that although the government set up a parallel supply chain procurement process that was designed to enable rapid procurement and processes were supposed to be in place to avoid waste, the parallel chain managed to buy equipment that did not meet the correct specifications thereby "wasting hundreds of millions of pounds." These included 75 million respirator masks, with a total cost of £214 million, that the NHS will not use for the original purpose. The DHSC told the NAO that 195 million items were potentially unsuitable.

In December 2021, the BBC NI Spotlight programme *(13)* investigated what happened to PPE worth £107.5m, that had been sold to the Department of Health and Social Care in Whitehall by Antrim-based confectionery company Clandeboye Agencies (on the VIP lane for procurement). The researchers discovered that PPE from the company was being sold on the open market on online auctions for a fraction of the cost paid for it by the NHS.

A box of personal protective equipment (PPE) which was sold to the NHS by Clandeboyes that cost the taxpayer more than £1,000 during the first wave of the Covid-19 pandemic has been sold on the open market for just £5.

11 – https://www.theguardian.com/politics/2022/feb/01/department-of-health-writes-off-9bn-spent-in-uk-covid-ppe-drive
12 –https://www.theguardian.com/politics/2022/feb/01/department-of-health-writes-off-9bn-spent-in-uk-covid-ppe-drive
13 – https://www.bbc.co.uk/news/northern_ireland



Fraud was possible

Whilst auditing the DHSC's accounts, Gareth Davies, the NAO's comptroller and auditor general, noted that PPE procurement had been vulnerable to fraud, as normal competitive tender processes were suspended and multimillion-pound contracts awarded to many companies with no previous experience. He said a "significant increase in new suppliers, a lack of timely checks on the quality of goods received and poor inventory management" had all contributed to a heightened risk of fraud in the PPE contracts. He had not been able to obtain assurance "that there is not a material level of losses due to fraud", he added. But as much of the equipment supplied remains in sealed containers, Davies said he had been unable to carry out sufficient checks to be satisfied that substantial fraud had not taken place.

The DHSC accepted in the annual report that its PPE procurement was susceptible to "heightened risk" of fraud, as "goods subject to detailed technical requirements were purchased from new suppliers … some of whom did not have experience in supplying these types of product".

… Test and Trace

Although referred to by the media as NHS Test & Trace, the vast majority of the contracts were awarded to private companies, without tender under emergency procedures or from existing framework agreements (lists of companies approved to do certain types of government contracts).

The system covers England and Wales and was led by Dido Harding, a Conservative peer and businesswoman who had previously worked for Tesco and TalkTalk. She was appointed by the then health secretary, Matt Hancock.

Test and trace failed its objectives

Test and trace was allocated a budget of £37 billion, but despite this enormous budget it failed to have any major impact on the trajectory of the pandemic, according to a damning report *(14)* from the Public Accounts Committee (PAC).

14 – https://publications.parliament.uk/pa/cm5802/cmselect/cmpubacc/182/report.html

"It was revealed in August 2020 that just 56% of close contacts handled online or by call centres run by Serco and Sitel were being reached. In contrast, the local council's contact tracers in the Blackburn with Darwen area managed to contact 90%, one of a growing number of councils that set up their own systems due to frustration with the centralised system."

In October 2021 the committee's report stated that the test-and-trace system has failed to achieve "its main objective" to cut infection levels and help Britain return to normal. The failure they outlined happened despite test and trace being allocated £37bn in taxpayers' cash - 20% of the NHS's entire annual budget over two years.

Dame Meg Hillier, chair of the committee, said: *"The national test-and-trace programme was allocated eye-watering sums of taxpayers' money in the midst of a global health and economic crisis. It set out bold ambitions but has failed to achieve them despite the vast sums thrown at it....Only 14% of 691m lateral flow tests sent out had results reported, and who knows how many took the necessary action based on the results they got, or how many were never used. The continued reliance on the over-priced consultants who 'delivered' this state of affairs will by itself cost the taxpayer hundreds of millions of pounds."*

The objective of test and trace was to identify people testing positive for Covid-19 quickly and instruct them to isolate, then to trace any contacts they may have passed the virus on to and instruct them to isolate for a period of time and to take a test. When carried out efficiently and quickly, this system can significantly reduce the spread of the virus in a population. In many countries, such as South Korea, such systems have worked well.

The failures of privatised test and trace in England and Wales

With the exception of the contact tracing app developed by the NHSX subsidiary, the system has always been run by private companies. Without competition, companies such as Serco, Sitel and Deloitte, were awarded massive contracts. These companies then sub-contracted out much of the work to smaller companies. When things began to go wrong it was the council-run contact tracing departments that often took over contact tracing. Private companies were involved at every level of the test & trace system - test centres, testing staff, test analysis, and tracing contacts. The major failures of private companies combined with errors of government policy led to Test & Trace, as the PAC noted, having no major impact on the trajectory of the pandemic.

App development

The only part of the test and trace system that was completely within the NHS was development of an app for contact tracing and informing people when they had been in contact with someone who had tested positive. Development was by NHSX, the NHS's technology department, which for some reason decided to develop its contact tracing app without the help of the two largest and most experienced app developers - Apple and Google - both of which had offered to collaborate.

Other countries enlisted the help of the giant tech companies and produced apps that worked on all phones and cost hundreds of thousands to develop. For example, Ireland's app *(15)* cost about £773,000 to develop. NHSX on the other hand developed an app which would not work on a large proportion of phones and the first phase of development cost £11 million. Instead of immediately changing tack and seeking help from Apple and Google for such an important part of the test and trace system, NHSX persisted in the development, wasting weeks of time and spending millions. Eventually the government conceded that it needed help and decided to join forces with the tech giants.

The app was finally released to the public in September 2020. Months had been wasted and millions of pounds. Elsewhere in the UK, the Northern Irish and Scottish executives both hired the company which designed the Irish app to design their own and it was expected to cost less than £1 million to build and operate.

Low level of contact tracing

The government's Scientific Advisory Group for Emergencies (SAGE) has stated that 80% of contacts with coronavirus cases need to be contacted and told to self-isolate in order for the system to be effective.

15 – https://fullfact.org/online/ireland-uk-tracing-app/

Serco and Sitel were awarded contracts to recruit thousands of people to carry out contact tracing. There was a big fanfare about the recruitment of 20,000 contact tracers when the system launched in May 2020. However, there very quickly appeared to be problems *(16)* with training of the tracers and how effective they were at contacting people.

Contact tracing is a specialist skill that needs tact to obtain sometimes sensitive information from ill people. The contact tracers recruited by Serco and Sitel had little or no experience and were given minimal training when hired on near-minimum wage. It was revealed in August 2020 that just 56% of close contacts handled online or by call centres run by Serco and Sitel, were being reached. In contrast, the local council's contact tracers in the Blackburn with Darwen area managed to contact 90%, one of a growing number of councils that set up their own systems due to frustration with the centralised system.

Self-isolation rate too low to have an impact

Even if NHS contact tracers reach 100% of coronavirus contacts, up to 80% of them would be required to self-isolate in order for the scheme to be effective. Self-isolation is difficult for many sections of society, in particular those on low wages and zero hours contracts - if you don't work, you don't get paid.

Finally, after much campaigning and research published in September 2020 that showed just 15% to 30% of people were self-isolating, the government introduced £500 in support *(17)* for people on low incomes whose finances would be impacted if they had to stay at home. Data from the ONS in August 2021 *(18)* reported that 88% of people self-isolated after being contacted, stable from June 2021, but down from 93% in May 2021.

The target to turnaround results for face to face tests has never been met

The Public Accounts Committee report *(19)* was heavily critical of the fact that the target to return results for all face to face tests within 24 hours has never been met. The target was there to ensure that positive results are communicated as soon as possible to minimise spread of the virus. The report notes that in December 2020 and April 2021, the test and trace system provided only 17% of in-person PCR test results within 24 hours, compared to 38% at the end of October 2020.

High payments to management consultants

From the start of the pandemic to January 2021, the government spent at least £375m on private consultancy services *(20)* for the test and trace system. In October 202021, Sky News reported *(21)* that more than 1,000 consultants from Deloitte were working on test and trace, which in pure headcount terms, is about the size of a small UK government department. Deloitte is the most dominant management consultancy, but consultants from McKinsey, BCG, PWC, KPMG and EY are also employed. The highest paid consultants were reported to be earning £6,624 a day.

Errors in data handling

There have been several incidents of data being lost from the system or not used correctly. After relaxation of the first lockdown, anyone wanting to enter a venue was told to either check-in by leaving contact information with staff or use the NHS app, so authorities could locate them if there was a Covid outbreak. However, the PAC report found that this data was "barely" used by privatised test and trace, which meant "thousands of people" were not warned they might be at risk of infection, "potentially leading to the spread of the virus".

From 25 September to 2 October 2020 some 16,000 positive cases *(22)* were left out of the UK daily case figures. They were then

16 – https://lowdownnhs.info/news/covid-contact-tracer-i-cant-say-ive-been-busy/
17 – https://www.gov.uk/government/publications/test-and-trace-support-payment-scheme-claiming-financial-support/claiming-financial-support-under-the-test-and-trace-support-payment-scheme
18 – https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronavirusandselfisolationafterbeingincontactwithapositivecaseinengland/9to16august2021
19 – https://publications.parliament.uk/pa/cm5802/cmselect/cmpubacc/182/report.html
20 – https://www.thetimes.co.uk/article/nhs-test-and-trace-consultants-on-163k-bt5lctn5r
21 – https://news.sky.com/story/coronavirus-more-than-1-000-consultants-from-deloitte-on-test-and-trace-programme-12099127
22 – https://news.sky.com/story/coronavirus-data-can-save-lives-data-can-cost-lives-and-this-latest-testing-blunder-will-likely-prove-it-12090904

"A report by the Centre for Health and the Public Interest in October 2021 noted that on 39% of days between March 2020 and March 2021, private hospitals treated no Covid patients at all and on a further 20% of days they cared for only one person. Overall, they provided only 3,000 of the 3.6m Covid bed days in those 13 months – just 0.08% of the total."

recovered and passed on to contact tracers. Some of those infection alerts were delayed by a few days, others by nearly a week. It makes it highly likely that some of those contacts who were not reached in time will unknowingly have spread the virus.

In May 2021, a software error meant that information on more than 700 infected people *(23)* and their close contacts were not promptly passed on to local health teams, allowing them to potentially spread the virus further. This is thought to have led to the rapid spread of a new variant. One of the most high profile was the hunt for an individual who had entered the country carrying a Brazilian variant of the virus. It took almost a month to track them down as they did not complete a passenger locator form in full and did not complete a test registration form when tested at the start of February 2021. The person was not located until 5 March, having freely circulated for almost a month.

Major failures at testing companies

In October 2021, the private company Immensa was shown to have returned 43,000 incorrect negative PCR test results between 8 September and 12 October 2021. The people had previously tested positive on a lateral flow device (LFD). The company's Wolverhampton laboratory was suspended from test and trace.

Dr Kit Yates, a mathematical biologist at the University of Bath, told The Guardian *(24)*: "We now know 43,000 people are believed to have been given false negatives, but this doesn't even come close to the cost of the mistake. Many of these people will have been forced into school or work, potentially infecting others. This could be part of the reason behind some of the recent rises [in cases] we've seen."

The laboratory was found to not be fully accredited to perform the testing work by the UK's independent accreditation service, Ukas, although the Department of Health had assured the media that it was. The Ukas accreditation is intended to ensure labs meet minimum quality standards. Companies require the certification, or must be in the process of applying for it, if they wish to provide Covid testing.

The Independent reported that whistleblowers *(25)* at the Immensa lab had revealed how machines were poorly maintained, and their concerns over quality control dismissed, and untrained staff regularly "left to their own devices". Samples at the Wolverhampton lab were wrongly processed or cross-contaminated, leading to incorrect test results, while faulty air conditioning and fluctuating humidity levels within the site also led to spoiled tests, one whistleblower has said. Another said that a focus was placed on "quantity over quality", with staff under pressure from senior management officials to process as many tests as possible each day.

... Hospital contracts

As NHS beds came under huge pressure during the pandemic, hospital bed capacity within the private hospital sector was reserved by the NHS, and at substantial cost. This could be justified to ensure that non-covid patients continued to be able to access the treatment they needed, however there is considerable evidence that these contracts were underused and did not represent good value for money for the NHS, although the private sector fared well financially.

Contract worth £1.57bn to private hospitals

In March 2020 the government agreed a contract to block-book the entire capacity of all 7,956 beds in England's 187 private hospitals along with their almost 20,000 staff. It is reported to have cost around £400m a month. The plan was for the private hos-

23 – https://news.sky.com/story/coronavirus-data-can-save-lives-data-can-cost-lives-and-this-latest-testing-blunder-will-likely-prove-it-12090904

24 – https://www.theguardian.com/world/2021/oct/15/covid-how-did-error-over-wrong-pcr-test-results-in-uk-happen

25 – https://www.independent.co.uk/news/health/covid-lab-wolverhampton-immensa-tests-result-b1945785.html

pitals to treat Covid-19 patients as well as providing Covid-19 free hospitals to carry out NHS elective surgery and cancer treatment, as the NHS hospitals began filling with Covid-19 patients. The contract was published in October 2020 and listed as worth £1.57bn.

The published contract reveals that the £1.57bn was shared between 26 private hospital corporations, each of which picked up payments ranging from £0.9m up to £346.6m which went to Britain's largest private hospital group, Circle Health, having completed the take over the previous market leader BMI Healthcare in mid-2020.

The other major recipients were Spire Healthcare Ltd (£345.9m), Australian-owned Ramsay Health Care (£271.1m), Nuffield Health (£165.2m), US-owned HCA International Ltd (153.2m), and Care UK with £76.3m. The remaining £218m was split between 20 smaller companies.

A second set of contracts for January to March 2021 was worth up to £474m. Unlike the first set these included minimum payments for making capacity available, as well as for services that were actually used.

Private sector benefited but did less work than normal

Although this use of the private sector appeared to be a positive move for working through the pandemic and enabling non-Covid work to continue in safety, it has become evident that the private hospitals did very well out of these contracts, receiving a large amount of money that helped them survive the pandemic, in return for a much lower amount of work than was anticipated. The initial £1.57bn contract meant the private sector received a set amount of money for making the capacity available (based on their running costs), rather than payment depending on how much work they carried out.

A report by the Centre for Health and the Public Interest *(26)* in October 2021 noted that on 39% of days between March 2020 and March 2021, private hospitals treated no Covid patients at all and on a further 20% of days they cared for only one person. Overall, they provided only 3,000 of the 3.6m Covid bed days in those 13 months – just 0.08% of the total.

Prior to the pandemic, private hospitals undertook 3.6 million NHS-funded planned procedures in 2019, which dropped to only 2 million during the first year of the pandemic – a fall of 43%.

Two letters had been sent to the wider NHS explaining why the deal had been struck and what it would cover, which made it clear that it would include care for Covid patients with serious breathing problems as well as routine operations, such as hip and knee replacements. However, the Independent Healthcare Providers Network, which negotiated the deal on behalf of private hospitals, insisted that it was never intended to cover people with Covid.

Sid Ryan, a researcher at the Centre for Health and the Public Interest who wrote the report, noted in The Guardian *(27)* that "Despite the fact that the taxpayer paid undisclosed billions to the private hospital sector, which prevented some of the companies going bust, the official data shows that they barely treated any Covid patients and delivered less elective work for the NHS than they did prior to the pandemic."

He added that the NHS's "under-utilisation of the private hospital sector" should not have surprised ministers, "because private hospitals may have beds and operating theatres, but they rely on NHS staff to carry out operations, and these NHS staff were busy working in NHS hospitals. Which begs the question: why then did the government agree to this generous deal?"

Contract was poor value for money

Although on the surface the use of the private system appeared to be a good idea, in fact most private hospitals are of limited use to the NHS for several reasons: they tend to be small in scale (averaging just 43 beds); geographically separate from the main NHS acute centres; and they are primarily staffed with nurses and relatively few doctors, most of whom work in them on a part-time sessional basis, while employed by the NHS. Making more use of private hospitals can therefore mean diverting more NHS staff to do the work, and separating them from the main clinical workforce.

Chair of the Public Accounts Committee, Labour MP Meg Hillier *(28)*, said the findings showed the government and NHS had got poor value for money from the very expensive deal. "Taxpayers have covered an entire year of private hospitals' costs in return for less treatment and care than before, and many of them now feel forced to pay those same private hospitals over again in the face of an NHS beset with lengthy backlogs."

26 – https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

27 – https://www.theguardian.com/world/2021/oct/07/private-hospitals-treated-eight-covid-patients-a-day-during-pandemic-says-report

28 – https://www.theguardian.com/world/2021/oct/07/private-hospitals-treated-eight-covid-patients-a-day-during-pandemic-says-report

How privatisation, underfunding and workforce issues interact – in three key sectors of the NHS

These three sectors, diagnostics/pathology, mental health and elective surgery offer an insight into how under-funding, neglect of workforce issues and outsourcing interact to the detriment of the NHS.

The same dynamic can be seen in other parts of the NHS too, but the way in which NHS clinical services have been outsourced in mental health and diagnostics offer important lessons about how a chronic lack of investment in both infrastructure and workforce has led to the substitution of private sector capacity, a pathway that elective care and other sectors in the NHS may follow.

All three sectors have been heavily impacted by the Covid-19 pandemic - diagnostics/pathology by an increase in waiting lists and an influx of new companies and infrastructure, mental health by a massive increase in need, and elective surgery by an increase in waiting lists and an increasing closeness of NHS and private hospitals.

Our analysis shows that government policy has consistently blocked the growth in the NHS and at the same time facilitated the gradual transfer of the supply of clinical functions to the independent sector, without proper planning, or public debate about the consequences.

Diagnostics/pathology

In the decade before the pandemic the private sector had already expanded its involvement into many diagnostics services within the NHS - from MRI scans, to the identification of bacteria in infected tissue, from genetic testing to a simple hearing test, and much of that expansion followed government legislation in 2012, which enforced greater competition for NHS contracts.

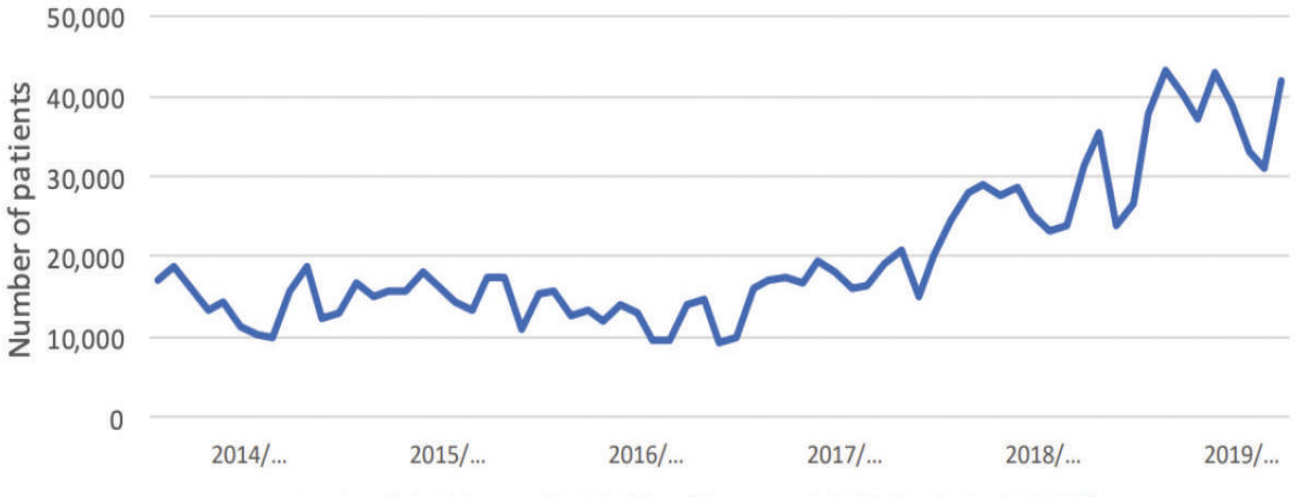
The current scale of commercial involvement is difficult to estimate, but in terms of diagnostic imaging alone the work performed by private companies accounts for around 15% of the total market value *(29)*, in a market heavily dominated by NHS contracts.

29 – https://www.businesswire.com/news/home/20200519005407/en/Insights-into-the-Diagnostics-Market-in-the-UK---1st-Edition---ResearchAndMarkets.com

Lack of NHS capacity has been the key to private expansion

Insufficient NHS capacity has been a key factor in the expansion in outsourcing to private providers. Over the last decade, researchers and NHS bodies have repeatedly signalled that there is a large shortage of trained NHS staff in diagnostics, in specialities like radiology, and persistent problems with insufficient or failing equipment.

Number of patients waiting 6+ weeks at month end for a diagnostic test

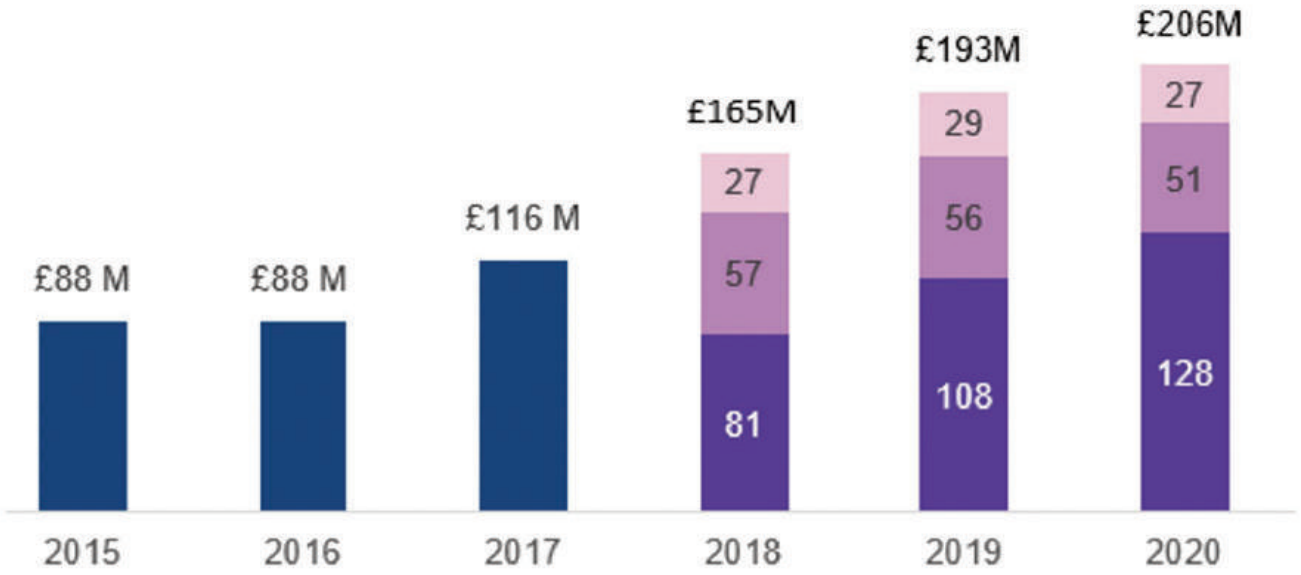


Source: NHS England

According to Prof Mike Richards who reported in 2020 to NHS England on how to respond *(30)* to this pressure, diagnostic services in the NHS were reaching a tipping point. His proof was the marked rise in missed targets and "the substantial increase in outsourcing of imaging (including reporting) and endoscopy" by NHS trusts across the country because they did not have the capacity to match demand.

The Richards review concluded that major expansion and reform of diagnostic services is needed over the next five years to facilitate recovery from the Covid-19 pandemic and to meet rising demand. Key policy ambitions in the NHS Long Term Plan, such as the goal to diagnose 75% of people with cancer at an early stage could not be achieved, he said, without big investment in facilities and workforce.

Estimated radiology expenditure (£m) on outsourcing, insourcing and ad-hoc locums – UK, five-year trend



Source: Royal College of Radiologists

30 – https://www.england.nhs.uk/wp-content/uploads/2020/10/BM2025Pu-item-5-diagnostics-recovery-and-renewal.pdf

"England lags far behind the OECD averages for scanners – a situation only made worse by many NHS trusts having to rely on charity efforts to buy large diagnostic equipment, and [also made worse] by equipment performance issues."

Long-term underinvestment in the sector

In pathology, the rising role of the private sector has run in parallel to a long term underinvestment in new NHS staff and facilities across the sector. This trend was very evident before the pandemic. A Royal College of Pathologists (RCP) workforce census *(31)* released in 2018, confirmed that outsourcing due to lack of NHS staff is routine.

Out of the 103 histopathology departments who took part, only 3% said they had enough staff to meet the current clinical demand and 45% of departments had to outsource work, while 50% of the departments were forced to use more expensive temporary workers. In diagnostics, similar findings were made by the Royal College of Radiologists in 2019 concluding that outsourcing due to understaffing *(32)* is also common in Radiology and has been rising sharply in recent years in response to a lack of investment in staff training.

In recent years there has been widespread consolidation and outsourcing in the network of pathology services, however in reviewing the impact the RCP concluded that "Much of the evidence about outsourced pathology services demonstrates that they are more expensive and provide an inferior service to the ones they replaced."

Lack of investment over the previous decade has led to the NHS in England lagging far behind the OECD averages *(33)* for scanners (CT, MRI and PET-CT) per million population, ranking lowest among 23 countries for CT scanner provision and 19th out of 21 for MRI equipment.

The Richards review and diagnostics

Prior to the pandemic NHS England was already reorganising diagnostic services within the NHS, based on the 2019 Long-term plan *(34)* and an independent review of the diagnostic capacity by Sir Mike Richards published in September 2020 *(35)*.

The Richards review recommended the development of around 150 community diagnostic hubs (CDH), a concept that was piloted in ten areas back in 2018 *(36/1)*. He also called for a major expansion of NHS capacity – in both workforce and scanner provision – as soon as possible, and recommended the increased use of independent sector facilities only during what it termed the 'recovery phase'.

Both the BMA and the Royal College of Radiologists made similar points a year later, suggesting workforce issues were a major constraint on the sector. It also highlighted the fact that England lags far behind the OECD averages for scanners – a situation only made worse by many NHS trusts having to rely on charity efforts to buy large diagnostic equipment, and by the sort of equipment performance issues uncovered during a Channel 4 documentary in October 2021 *(36/2)*.

The Dispatches production team revealed that CT and MRI scanners older than ten years, potentially putting patients' health at risk, are still being used by about a third of hospital trusts *(37)*, despite an NHSE report published last year that recommended that all imaging equipment aged ten years or older be replaced.

The programme makers also found that coroners were concerned about the shortage of radiology staff, as well as poor CT and MRI scans. More worryingly, they also found 48 reports over the past five years that mentioned a lack of scans and/or radiology.

31 – https://www.rcpath.org/discover-pathology/public-affairs/the-pathology-workforce.html
32 – https://www.rcr.ac.uk/posts/nhs-does-not-have-enough-radiologists-keep-patients-safe-say-three-four-hospital-imaging
33 – https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf
34 – https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
35 – https://www.hsj.co.uk/quality-and-performance/nhs-invites-bids-for-10bn-diagnostic-programme/7030398.article
36/1 – https://www.pulsetoday.co.uk/news/clinical-areas/cancer/one-stop-shop-cancer-diagnosis-centres-to-investigate-non-specific-symptoms/
36/2 – https://twitter.com/C4Dispatches/status/1449768071498018817
37 – https://www.theguardian.com/society/2021/oct/18/nhs-england-hospitals-having-to-rely-on-obsolete-imaging-equipment

Where now for diagnostics/pathology?

The pandemic has exacerbated the already massive gap in NHS capacity, waiting lists for all diagnostic procedures have lengthened.

However, instead of heavy investment in increasing NHS capacity, through new laboratories and new diagnostics hardware, and increasing the workforce. The government's policy response has been to scale up private sector involvement still further. This is the case both in pathology, such as testing for cancer and infectious disease, and in diagnostics procedures, such as MRI and CT scans.

The huge commercial involvement in the Lighthouse Labs that were constructed to support mass testing during 2020/21 has set the trajectory for policy going forward. These policies bypassed *(38)* the existing network of 44 NHS labs and the public health teams that had local knowledge and training in contact tracing.

The Lighthouse Labs and pathology

In April 2020 The Lighthouse Labs were created through a partnership between the Department of Health and Social Care, and a number of commercial companies and academia *(39)*, including Medicines Discovery Catapult, UK Biocentre, the University of Glasgow, AstraZeneca, BioAscent Discovery Ltd and GSK.

The DHSC *(40)* has admitted that the Lighthouse lab network, created using an emergency procurement policy *(41)*, is entirely separate to England's existing complement of NHS and PHE laboratories, although it claims NHS trusts remain as potential 'suppliers'. Only three of the mega labs announced in September 2020 will be NHS-managed *(42)*.

A former director of the World Health Organisation, Professor Anthony Costello, was a vocal critic of this new parallel network

38 – https://lowdownnhs.info/comment/why-bypass-nhs-labs-for-mass-testing-concerns-over-new-super-labs/

39 – https://www.researchprofessionalnews.com/rr-news-uk-innovation-2020-4-hancock-launches-first-of-three-mega-labs-for-covid-19-testing/

40 – https://www.gov.uk/government/news/500000-daily-testing-capacity-reached-in-ongoing-drive-to-boost-test-and-trace

41 – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/873521/PPN_01-20_-_Responding_to_COVID19.v5__1_.pdf#:~:text=direct%20award%20due%20to%20extreme%20urgency%20%28regulation%2032%282%29%28c%29%3B,an%20existing%20framework%20agreement%20or%20dynamic%20purchasing%20system%3B

42 – https://www.gov.uk/government/publications/nhs-test-and-trace-how-we-test-your-samples/nhs-test-and-trace-how-we-test-your-samples

to the NHS, pointing to the fact that the existing 44 NHS labs in the UK were underused *(43)*. The Institute for Biomedical Science also raised concerns about the standards of training and procedures.

By October 2020 the system had been struggling with processing tests and tracking contacts quickly enough. The Scientific Advisory Group for Emergencies advising the Prime Minister issued damning criticism of the government's "world-beating" test-and-trace system, concluding that it had only a "marginal impact" in reducing the spread of the virus. In one instance an IT error led to 16,000 positive cases *(44)* being dropped from the data and their contacts not traced.

Despite the problems a month later Matt Hancock *(45)*, then Health and Social care Secretary, gave a clear steer on his intention to make the Lighthouse Labs a permanent part of the UK's new diagnostics industry, in effect using the pandemic to strengthen the commitment towards the outsourcing of NHS diagnostic functions.

Then in May 2021 some of the early concerns about the way the Lighthouse labs were set up seemed justified by new evidence from an undercover report by BBC's Panorama which found that one of the UK' s largest Covid testing laboratories in Milton Keynes could be returning false results due to contamination and lack of quality control.

A virologist working at the lab told the BBC that his fellow workers had limited laboratory experience and were not given proper safety induction and he called the working practices "chaotic and dangerous".

According to the IBMS, a further concern was that the non NHS Lighthouse labs would likelyundermine the NHS by exacerbating its workforce issues in a sector where the main problem was a lack of trained staff. In a statement they pressed for the merging of the existing NHS labs with the new testing centres into "one stream".

Where next for the testing labs and its workforce?

Two years on and the decision to end free testing means a further significant swerve in policy that will affect all the test and trace facilities. Some were already being downsized, but this latest policy change means a further drop in demand with around 1000 staff already under threat. The transfer of staff to the NHS may be possible and welcome, but some NHS managers are now questioning whether they have the funding to employ these much needed staff.

The strategic decision to focus resources on a new network of commercially dominated labs, that now have an uncertain future raises further questions as to why investment wasn't channelled towards the NHS to augment the existing NHS network as part of a longer term strategy.

Private involvement in diagnostics a part of policy

Both the major strands of policy for diagnostic networks and community diagnostic hubs, allow private operators to be involved and guidance produced by NHS England in April 2021 appears to encourage that involvement. The guidance states that NHS trusts have until 2023 to set up separate entities to run their diagnostic imaging services, and the networks will be "significant operating businesses in their own right". It gives trusts seven options for setting up a network, Only "Collaboration" between trusts and "Outsourcing" to a commercial partner get a "Highly feasible" note in the comparison table of the different options.

In early 2021, NHS England advertised a multi-year framework agreement worth up to £10bn *(46)* to provide services at around 150 planned new community diagnostic hubs to provide an extensive range of services, including, imaging capacity for CT, MRI, ultrasound, X-ray; cardiorespiratory capacity, including echocardiography, ECG and rhythm monitoring, and many many more procedures.

The HSJ reported *(47)* that the Independent Healthcare Providers Network chief executive David Hare welcomed the framework, saying "a mixed economy" of independent and NHS providers would likely be used for the new CDHs.

In March 2022 an investigation by journalists at openDemocracy *(48)* found that just 17 of the 69 CDHs that Sajid Javid had spoken about the previous month were actually up and running. Most of these had extensive private involvement.

With a major expansion of the CDH concept now underway, however, outsourcing isn't the only way the independent sector is

43 – https://www.dailymail.co.uk/news/article-8180921/Testing-fiasco
44 – https://www.bbc.co.uk/news/uk-54412581
45 – https://www.gov.uk/government/speeches/health-and-social-care-secretarys-statement-on-coronavirus-covid-19-16-november-2020
46 – https://uk.eu-supply.com/ctm/Supplier/PublicTenders/ViewNotice/26139
47 – https://www.hsj.co.uk/quality-and-performance/nhs-invites-bids-for-10bn-diagnostic-programme/7030398.article
48 – https://www.opendemocracy.net/en/sajid-javid-nhs-diagnostic-centres-waiting-times-not-exist/

increasingly moving into NHS community diagnostics – public-private partnerships are taking off too, on the back of CDHs.

October 2021 saw the launch of the Rutherford Diagnostics Centre in Taunton *(49)* – run by Rutherford Diagnostics Ltd, a subsidiary of Rutherford Health, in a five-year partnership deal with Somerset NHS Foundation Trust, and the company plans four more CDHs under a £55m agreement with "infrastructure investor and developer" Equitix, whose CEO in the accompanying press release stated that he was pleased that his company was "adding these assets to our institutional asset portfolios".

There will undoubtedly be other such partnerships emerging over the next six months as more CDHs are established across the UK, potentially favouring the independent sector in much the same way as the 'mega lab' Lighthouse diagnostics project – covered extensively by The Lowdown over the past 12 months – has already appeared to have done.

Mental health

There is now substantial data on the effects of the pandemic on the nation's mental health. In November 2021, Senior Responsible Officer for Mental Health, Claire Murdoch's, report to the board meeting *(50)* of NHS England and NHSI noted that at least 1.4 million people are on the waiting list for care, with an additional eight million who would benefit from care, but who do not meet current criteria.

The increase in mental health need stems from those who were denied care during lockdown; those whose health deteriorated and from new patients, flowing from the wider impacts of the pandemic, such as self-isolation and increases in substance abuse and domestic violence. However, a study published in March 2021 in Lancet Psychiatry found that overall one in three people who recover from coronavirus develop a neurological or a psychiatric condition within six months, which adds a whole new population to those needing treatment and care.

49 – https://www.rutherfordhealth.com/article/news/patients-in-somerset-and-surrounding-areas-to-benefit-from-pioneering-community-diagnostic-hub

50 – https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-5-251121-update-on-mental-health-services.pdf

Fall in capacity

As a part of a policy to move mental health services into the community *(51)*, NHS inpatient mental health bed numbers fell from 23,208 in September 2011 to 18,179 in September 2019 before the pandemic began. Over the next two years of the pandemic, capacity changed little and stood at 18,232 in December 2021 *(52)*.

Mental health nursing has by far the greatest nursing vacancy rates ranging from 12% to almost 22% in the south east: indeed while overall nurse numbers have increased, there are still fewer mental health nurses than there were in 2010.

This reduction in NHS capacity over the past decade, despite an increase in need, meant that the NHS had already been forced to turn to the private sector even before the pandemic began. In 2020 the private sector had just over 9,000 beds, the majority of which were used by the NHS, under contract. The income of one of the leading companies in the sector, Cygnet Healthcare *(53)*, is almost entirely from NHS contracts and most companies in the sector gain the majority of their income from the NHS.

According to a recent report from healthcare analysts, Laing & Buisson *(54)*, the independent sector now receives about 13.5% (£1.964bn) of the £14.8bn the NHS in England spends on mental health, up from £951m in 2005. An indication of just how reliant the NHS has become on the private sector.

Despite all the evidence of an increased need, mental health services have received a small proportion of the extra funding from the government targeted at recovering from the pandemic, with the vast majority of the extra funding going to tackling waiting lists for elective surgery *(55)*.

What money mental health services have received has gone to community services, such as helplines, and mental health support teams in school. Some money has gone into acute inpatient services, but to convert dormitory accommodation to single rooms, which although much needed should really have been carried out years ago and does nothing to increase capacity.

The result of this lack of funding is that there is now intense pressure for beds *(56)*. At the end of December 2021 data on mental health services in London was leaked to The Independent *(57)*, which showed critical levels of bed availability. In October and November almost all mental health hospitals in London had been at "black alert", which means their beds were at nearly 100% occupancy;

51 – https://lowdownnhs.info/comment/policy-of-underfunding-and-outsourcing-fails-mental-health-patients/
52 – https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/
53 – https://www.nhsforsale.info/private-providers/9526-2/
54 – https://www.theguardian.com/society/2022/apr/24/nhs-paying-2bn-pounds-a-year-to-private-hospitals-formental-health-patients?CMP=share_btn_tw
55 – https://lowdownnhs.info/news/low-nhs-capacity-in-mental-health-leaves-it-beholden-to-private-companies/
56 – https://lowdownnhs.info/news/mental-health-data-backs-up-concerns-over-services/
57 – https://www.independent.co.uk/news/health/mental-health-nhs-covid-pressure-b1964693.html

a source told the paper that the situation was similar across the country, with nearly all mental health trusts at 94% bed occupancy.

The Independent also revealed that long waits for a bed were increasing in London, with 50 patients a week waiting more than 12 hours for a bed, compared with 35 during the same period in 2020. However, sources told the paper that the true length of A&E waits are often hidden, with many waits measured in days. One senior director in London, speaking anonymously with The Independent, said they'd seen a child wait 60 hours for a bed earlier this month, while another emergency care doctor said patients in their A&E were waiting for 18 hours.

Bed availability data for children in London showed just 10 children's beds out of 140 available in mid-October. Sources in the east of England told The Independent that almost 150 children's mental health beds were closed, which was causing huge pressures.

Private sector cuts beds

Now with the massive increase in need for mental health services and the lack of any investment in increasing NHS capacity, the NHS has become even more reliant on the private sector. There are major issues with this reliance, including lack of control over bed numbers, a focus on profits, and serious concerns over the safety and quality of care provided by private providers.

Now a new issue has entered the mix; a government policy that has consistently refused to come up with a workforce strategy *(58)* to ensure sufficient numbers of staff are trained and available to work, is impacting on the government policy of relying on the private sector to make up for a lack of NHS capacity.

The past few months have seen private companies reducing bed numbers as they struggle to recruit enough staff. A report in the FT in February 2022 *(59)* notes that despite a sharp increase in need, the private sector is cutting beds for children, with it notes about 325 beds removed in the past five years, which leaves just 1,321 beds for children and teenagers in England.

The Priory, the UK's largest private mental healthcare provider, told the FT that the closures of beds were "the result of having to address a sector-wide shortage of specialist child and adolescent clinical staff" and reducing beds enabled the company to maintain standards and deliver the care expected by the CQC.

The past two years have seen a number of hospitals run by private companies castigated by the CQC, particularly in the area of CAMHS. The two leading companies, The Priory *(60)* and Cygnet Healthcare *(61)*, have both had to close wards as a result of damning CQC reports, and St Andrews Healthcare the leading not-for-profit in the sector has had severe limitations put on its services after similar reports. St Andrews Healthcare has now significantly scaled back its CAMHS services and announced plans to sell its Mansfield site to Nottinghamshire Healthcare NHS Foundation Trust.

The CQC reports have often focused on staffing issues, and shocking incidents of staff behaviour have hit the headlines. The website NHSforsale.info contains more details of poor care and safety issues that have been highlighted by whistleblowers and the CQC at hospitals run by private companies *(62)*, including Cygnet Healthcare, The Priory, and Elysium Healthcare (now better known as Ramsay Health).

The issue of staffing is not restricted to CAMHS wards, CQC visits to St Andrews Healthcare's hospital in Northampton *(63)* last year led to it being prevented from admitting new patients to some wards without prior consent from the CQC. Short-staffing was a major issue plus not all staff were suitably qualified or competent for their roles. St Andrews was told that it must ensure adequate staffing levels and provide staff with appropriate training for their roles.

Shrewsbury Court Independent Hospital in Surrey run by the Whitepost Health Care Group, closed in December after the CQC imposed urgent conditions *(64)* requiring rapid improvements at the site. It provided long stay and rehabilitation services for people with mental health conditions, plus a learning disability and autism service.

The Whitepost Health Care Group, took the decision to close the hospital due to "a combination of ever-increasing pressures within our sector, operational demands, the age of the building, and challenges with recruitment."

There is some logic in cutting bed numbers, so that the staff the companies do have are sufficient for the number of beds and the

58 – https://www.health.org.uk/news-and-comment/news/nhs-staff-survey-signals-urgent-need-for-a-workforcestrategy
59 – https://www.ft.com/content/27818675-ee95-4915-a956-6a387abc599d
60 – https://www.nhsforsale.info/private-providers/the-priory-partnerships-in-care-new/
61 – https://www.nhsforsale.info/private-providers/9526-2/
62 – https://www.nhsforsale.info/private-providers/
63 – https://www.cqc.org.uk/news/releases/cqc-takes-action-st-andrew%E2%80%99s-healthcare-following-inspections-men%E2%80%99s-women%E2%80%99s-services
64 – https://www.cqc.org.uk/news/releases/cqc-takes-action-protect-people-shrewsbury-court-independent-hospital

short-staffing issue is solved, but with the NHS so reliant on the private sector, there are concerns that any reduction in beds will mean the private providers will charge the NHS higher fees for care, which costs between £500 and £1,300 a bed a day *(65)*.

Travelling further for care

The lack of capacity in mental health services (both NHS and private) leads to patients being sent further and further away from their support networks.

Known as Out of Area Placements (OoAPs), the government has already missed targets for reducing their number. A reduction in bed numbers in the private sector and no increased capacity in the NHS will make any reduction harder still. With OoAPs there are concerns about the quality of care provided; the disruption to individuals and their families; and the high cost of such care. The Independent reported *(66)* in January 2022 that OoAPs have increased due to a lack of beds with The Independent reporting that during one week in November, just 3% of beds for women were available in the capital and on one day, 40 patients had been sent miles away from home.

Lack of investment in NHS beds has also led to the treatment of some patient groups being almost entirely reliant on private companies, with a high number of OoAPs.

A recent report from the British and Irish Group for the Study of Personality Disorder *(67)* found that due to lack of investment in NHS capacity, care for patients with personality disorders appears to have been fully privatised and this has a negative effect on patient care. The report is the first to look specifically at the use of OoAPs for people with a personality disorder diagnosis and although hampered by a lack of information forthcoming from CCGs, Keir Harding one of threports authors writing in the HSJ *(68)* noted that: "The report found that OoAPs were provided almost exclusively in the private sector. With less than 50 beds for this client group in the NHS, it can be argued that with no consultation or planning whatsoever, we have privatised inpatient care for those who have lived through trauma"

The report also noted that these privately-run units that call themselves a "Specialist Personality Disorder unit" often have nothing to back up these claims and they can not be rated easily as there are no set criteria. Harding noted that "the testimonies of people who have been in such units in the report describe conditions akin to Winterbourne."

65 – https://www.ft.com/content/27818675-ee95-4915-a956-6a387abc599d
66 – https://www.independent.co.uk/news/health/mental-health-nhs-covid-pressure-b1964693.html
67 – https://bigspd.org.uk/wp-content/uploads/2022/01/OOA-Report-A4-NEW-v2.pdf
68 – https://www.hsj.co.uk/policy-and-regulation/care-of-those-with-personality-disorders-has-been-privatised/7 031682.article

The report also found that the market for such units is dominated by the two leading private companies, The Priory and Cygnet Healthcare. With the places so sought after and no additional capacity being opened by the NHS, this group of patients is unlikely to receive the care they need and deserve.

Hospitals

Waiting lists are predicted to reach *(69)* 13 million over the coming months, and the burden on the NHS has never been higher. In February NHS England published *(70)* a Delivery Plan which sets a headline need to increase elective activity by 30% above pre-pandemic levels by 2024-25, as a central part of reducing waiting times. It pledges to introduce "more than 100 diagnostic centres" and says "new surgical hubs will also be added to the network of 122 already operating across the country".

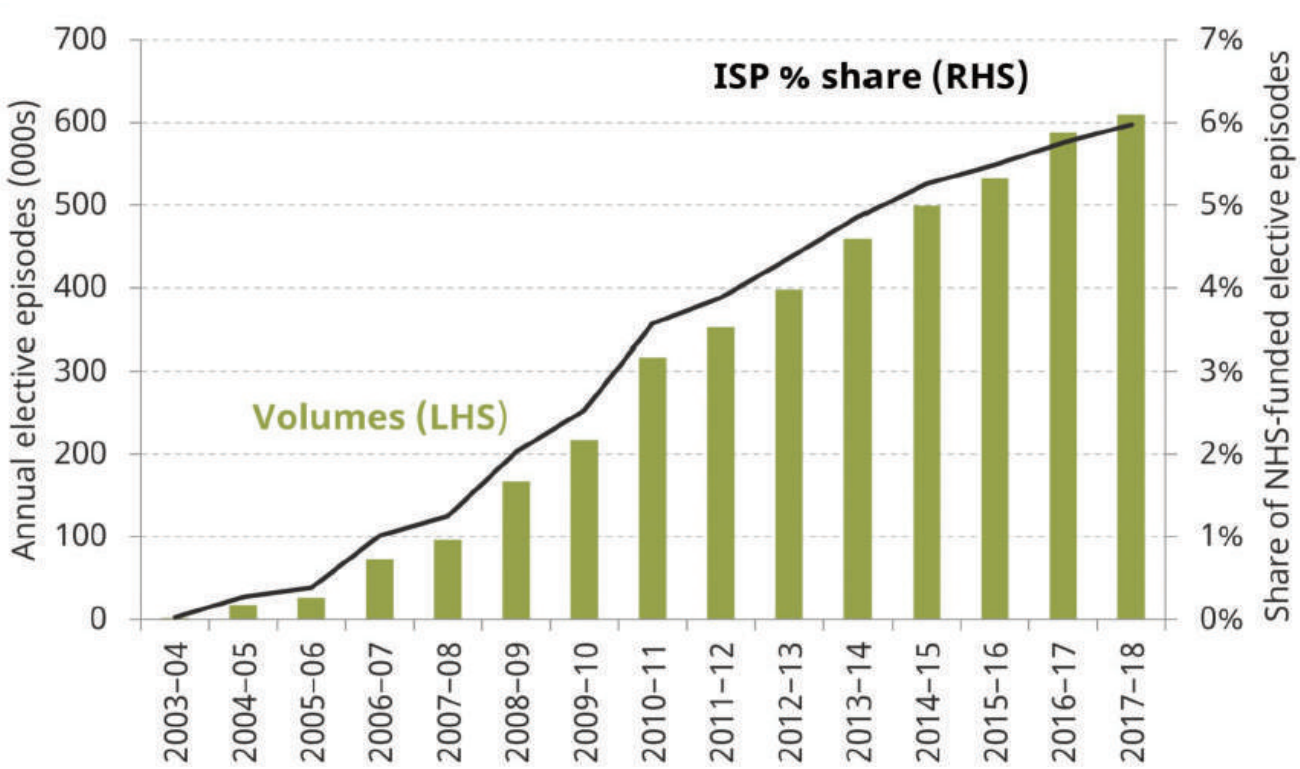
Although the NHS is already working hard to reduce waiting times - 23,000 patients have been on the list for longer than two years, its ambitions to expand services have since been tempered sharply by a further funding update from the Health Secretary Savid Javid who in a speech *(71)* in March confirmed that any new recruitment and training required to fuel capacity building would have to be met from within existing budgets - no new funding would be available.

In response the NHS Confederation said it was "difficult to see how benefits will be delivered without a fully funded workforce plan to address shortages".

Many NHS leaders share the view that current funding is insufficient to adequately retain and recruit staff. This message has been sent repeatedly to the government over a number of years and despite the publication of the NHS People Plan no funded workforce plan has emerged, resulting in widespread criticism of the treasury for resisting what many see as the number one priority *(72)* for the NHS in policy terms.

Given the delays in this investment and the scale of the new challenge of meeting sky high demand this is clearly the moment to act to invest in NHS staff, in buildings and new equipment as part of a long term strategy.

Annual volume of NHS-funded elective episodes at ISPs, 2003-18



Source: IFS

69 – https://ifs.org.uk/publications/15560#:~:text=The%20analysis%20shows%20that%20whether,13%20million%20%E2%80%93%20or%20even%20higher.

70 – https://www.england.nhs.uk/2022/02/nhs-publishes-electives-recovery-plan-to-boost-capacity-and-give-power-to-patients/

71 – https://twitter.com/i/broadcasts/1djGXPZoVaOGZ

72 – https://www.hsj.co.uk/workforce/a-fully-funded-workforce-plan-is-an-absolute-priority/7031286.article

The view from within the NHS is broadly that the current funding commitment - higher than in recent years, but on par with the historic average for the NHS, is welcome but not enough to achieve the key goals in the NHS Long Term Plan. The IFS say it's probably enough for the next two years but not beyond that - but subsequent inflation projections have undermined that analysis.

Restricted options

Without adequate long term funding the options for the Delivery Plan are limited, and this is reflected in its priorities for achieving higher activity levels and depend upon deploying new technology, revising working practices, efficiency savings and increased partnerships with the independent sector.

The role of private health companies was confirmed as a key pillar in the most recent guidance about how the Delivery Plan will be implemented. "Systems will incorporate local independent sector capacity as a core element of elective recovery plans to deliver improved outcomes for patients and reduce waiting times sustainably. "

A deal with the independent sector has already been renegotiated *(73)* to extend emergency arrangements to secure access to the capacity of independent hospital providers to help lessen waits for diagnostic tests and operations.

Alongside this government has awarded places on a 4 year framework agreement worth £10bn to a list of 90 private health companies to enable them to more easily enter in arrangements to supply local NHS hospitals with diagnostic and surgery services.

However as we explore below, there are limits to the extent that this approach can deliver extra capacity in the short term and in the long run, and without an investment strategy designed to introduce extra NHS capacity it has large implications for the future of the NHS, and challenge the deliverability of its core principles.

Details of £10 billion contract NHS England for increasing capacity in the NHS

Companies listed on award	Amount	Commissioning Organisation	Description	Date award published	Details
Circle Health, Guardant Health, Healthshare Ltd and others	Part of £10 bn (three awards published)	NHS England	Provision of NHS inpatient and day case services (including full supporting pathology and imaging) and urgent elective care and cancer treatment; NHS diagnostic services; and clinical facilities and related services Framework lists companies that have been approved for the work.	28/6/2021	NHS England IC Framework — NHS Increasing Capacity Framework *(74)*
4Ways Healthcare Ltd, Alliance Medical, Aspen Healthcare Ltd and others	Part of £10 bn (three awards published)	NHS England	Provision of NHS inpatient and day case services (including full supporting pathology and imaging) and urgent elective care and cancer treatment; NHS diagnostic services; and clinical facilities and related services	10/2/2021	NHS Increasing Capacity Framework *(75)*

73 – https://www.england.nhs.uk/2022/01/nhs-strikes-new-covid-surge-deal-with-independent-sector/

74 – https://ted.europa.eu/udl?uri=TED:NOTICE:324792-2021:TEXT:EN:HTML&src=0&act=nav

75 – https://ted.europa.eu/udl?uri=TED:NOTICE:70725-2021:TEXT:EN:HTML&src=0&act=nav

			Framework lists companies that have been approved for the work.		
Alliance Medical, Aspen Healthcare, Beacon Medical Services Ltd and many others	Part of £10 bn (three awards publishe d)	NHS England	Provision of NHS inpatient and day case services (including full supporting pathology and imaging) and urgent elective care and cancer treatment; NHS diagnostic services; and clinical facilities and related services. Framework lists companies that have been approved for the work.	16/4/20 21	NHS England IC Framewor k — NHS Increasing Capacity Framewor k *(76)*

The limits of independent sector support

Despite the new contracts there are practical and commercial limits to the assistance private hospitals can give to the NHS. Its bed capacity of around 8000, is less than 10% of the NHS.

During the pandemic the government secured 100% access to independent sector capacity, when it looked like the NHS might be completely overwhelmed. In the end these beds were heavily underutilised and currently only a fraction of the 8000 beds is being used for NHS patients, in part because long NHS waiting lists are proving a commercial opportunity for private operators, through a new stream of private patients who can afford to pay to bypass long NHS waits.

According to the Royal College of Surgeons, the "large majority" of doctors undertaking private practice also work in NHS consultant posts *(77)*, and only a small proportion of doctors work in full-time private practice only. Therefore in reality there is a limit to how far the independent sector can provide additional capacity without affecting the time these surgeons have left to work on their existing NHS or private lists, as noted in the eye surgery case study below.

A longer term contract arrangement, with an improved tariff offer for elective work from the NHS might encourage the independent sector to invest in expanding its own hospital bed stock and workforce, however the current 4 year, £10bn deal does not yet offer great certainty to private investors.

A BMA survey confirmed the trade off for private providers, many of whom have already disturbed the service to their fee paying patients in taking NHS work. The study found that 60% of the private practice doctors who responded were unable to provide care to their private patients and approximately 25% reported that private patients presented later than they should have - citing NHS bed reservation and subsequent limited capacity as the reason.

How much NHS surgery is currently done by the private sector?

Pre-pandemic the proportion of NHS surgical work done in private units was relatively small, at around 6%, or 600,000 NHS patients out of 16 million procedures, but in some specialties outsourcing of surgery has grown rapidly, making the NHS heavily dependent on a small number of key contractors.

A quarter of all eye procedures on NHS patients are now performed in the independent sector. This fact has alarmed NHS surgeons, 200 of whom signed a joint letter raising the negative impacts upon the training of new surgeons, principally as they don't have the spread of cases they need.

The Royal College of Surgeons share these concerns and note that "private providers often choose patients who are the lowest clinical risk for them to treat."

"We are also aware that obstetrics and gynaecology trainees are experiencing similar issues with the loss of training opportunities as benign gynaecology procedures, such as treatment for fibroids and endometriosis, are increasingly taking place in the independent sector."

76 – https://ted.europa.eu/udl?uri=TED:NOTICE:70725-2021:TEXT:EN:HTML&src=0&act=nav

77 – https://www.rcseng.ac.uk/careers-in-surgery/surgeons/practising-as-a-surgeon/private-practice/#:~:text=Of%20those%20doctors%20undertaking%20private,full%2Dtime%20private%20practice%20only.

For orthopaedics, the NHS is now heavily reliant on the private sector, 56% of all NHS hip and knee operations were performed by private providers over the last year according to research by Candesic. This figure is up from 40% two years ago, although the pandemic has been a factor.

The current shortage of 1,400 NHS anesthetists looks to get worse with 25% of NHS consultants thinking of leaving within the next five years due to a feeling that they are not being valued and the high pressure of work.

In comparison to other nations, England has a very low proportion of doctors relative to the population. The average number of doctors per 1,000 people in OECD EU nations is 3.7, but England has just 2.9. Germany, by comparison, has 4.3.

The BMA has calculated that England needs nearly 50,000 additional FTE doctors simply to put us on an equivalent standard with today's OECD EU average of 3.7 doctors per 1,000 people.

Impact of outsourcing: eye surgery

As Sajid Javid announces further private sector involvement in the NHS with the Elective Recovery Plan *(78)*, there were warnings from ophthalmologists that the safety of NHS patients could be put at risk if the private sector is given any more NHS work.

In a letter, signed by nearly 200 ophthalmologists and sent to NHS England and the Royal College of Ophthalmologists and shared with The Independent, they warn of "the accelerating shift towards independent sector provision of cataract surgery" which is already having a "destabilising impact" on safe ophthalmology provision.

They predict that the wide scale use of private providers will "drain money away from patient care into private pockets as well as poaching staff trained in the NHS." adding that "urgent action" is needed to prevent further work being given to the private sector.

Staff who would normally do extra hours for the NHS are now being offered better paid work doing cataract operations in the private sector, but this means other eye procedures are not being carried out for the NHS and waiting times for these will grow.

The private sector is already heavily involved with the area of cataract surgery; in November 2021, the Royal College of Ophthalmologists reported that in 2016, 11% of NHS cataract procedures in England were delivered by private companies, but by April 2021 there was almost a 50/50 split, with 46% in the private sector and 54% by NHS trusts and treatment centres.

Cataract surgery is the main training ground for junior doctors, they need to complete at least 350 cataract procedures to be able to then manage more complicated work. The use of the private sector means trainees are finding it harder and harder to access the opportunities. The NHS is left with the more complex cases, which are less suitable for training. This is making it more difficult for trainees to successfully complete training and, most importantly, more difficult to develop skilled and experienced surgeons.

78 – https://www.england.nhs.uk/2022/02/nhs-publishes-electives-recovery-plan-to-boost-capacity-and-give-power-to-patients/#:~:text=By%20July%202022%2C%20no%20one,18%20months%20by%20April%202023.&text=Returning%20the%20number%20of%20people,pandemic%20levels%20by%20March%202023

At the end of December 2021, the waiting list for elective surgery hit a record 6.1 million *(79)*, including over 600,000 waiting for eye procedures, according to The Royal College of Ophthalmologists.

As in other sectors where outsourcing has expanded there is a concurrent shortage of NHS staff in Ophthalmology, and signs of a lack of workforce planning, which predates the pandemic by some years.

In 2018 The Royal College of Ophthalmologists (RCOphth) identified gaps in the recruitment of ophthalmologists and in workforce planning and noted an estimated 40% increase in demand over the next 20 years against a "severe shortage of ophthalmologists and clinical space" with 67% of hospital eye units using locum doctors to fill consultant posts, an increase of 52% since 2016.

Ambulances

As long ago as April 2018, the Observer conducted a survey of the ten NHS regions and found that ambulance services across England were already short of nearly 1,000 frontline staff *(80)*, with LAS recording the highest tally of unfilled posts. In early 2020, the Care Quality Commission downgraded LAS' safety rating *(81)*, citing concerns that the service had too few staff to answer 999 calls consistently.

The situation has inevitably become a huge cause for concern in unions representing paramedics and support staff. In 2021 Unison *(82)* wrote to the Association of Ambulance Chief Executives highlighting unsustainable demand, and suggested that "the only long-term solution to the crisis for the ambulance services is continual investment in the workforce to deal with the demand".

A rise in outsourcing has run alongside the shortage in staff. An investigation in 2019 found that England's ambulance trusts spent more than £92 million on private ambulances and taxis to transport patients.

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79 – https://www.theguardian.com/society/2022/feb/10/number-of-people-in-england-on-nhs-waiting-list-hits-record-high
80 – https://www.theguardian.com/society/2018/mar/31/ambulance-crews-burnout-shortages-nhs-paramedics
81 – https://www.independent.co.uk/news/health/london-ambulance-staff-shortages-999-emergency-calls-cqca9267961.html
82 – https://www.unison.org.uk/blogs/2021/08/blog-call-999-the-terrifying-crisis-in-the-ambulance-service/

Press Association (PA) research found that trusts are increasingly relying on private ambulances *(83)* to attend 999 calls, almost one in five emergency calls result in a private ambulance being sent to the scene, and the change stemmed from a chronic shortage of NHS staff *(84)* and ongoing problems with recruitment, according to some managers commenting on the investigations.

In 2019 a Care Quality Commission (CQC) report *(85)* highlighted the activities of some of these companies, putting patients at risk. Lack of proper checks and insufficient training were leading to unacceptable exposure to harm.

Cleaning services

One of the first parts of the NHS to make widespread use of outsourcing, the impact of this policy has had time to be examined and absorbed leading to some NHS hospitals to bring these services back in house. In 2021 Imperial College Healthcare Trust and Great Ormond Street Hospital for Children (GOSH) declared they will end outsourcing and directly employ cleaners as NHS staff.

During the pandemic cleaning companies were criticised *(86)* for not providing enough PPE for staff, particularly as high numbers of asian and black people work for these companies and were disproportionately affected by the coronavirus.

Trade unions and campaigners have been active in campaigns around this area of outsourcing and research about the impact has been emerging. A key study of 126 NHS trusts by University of Oxford in 2016 showed that NHS hospitals who employ private cleaners are associated with a higher incidence of MRSA, a 'superbug' that causes life-threatening infection and has previously been linked with a lack of cleanliness. Professor David Stuckler, said at the time "Our study finds that contracting out NHS services may save money, but this at the price of increasing risks to patients' health. When these full costs are taken into account, contracting may prove to be a false economy'

Inequity from outsourcing

Waiting lists have not grown evenly across the country, rising faster *(87)* in poorer areas. As the Inverse Care Law suggests these areas are already starting from a lower base of healthcare resources, but the wider use of private hospitals for NHS treatment will accentuate some of these differences. Private hospitals are not evenly sited across the country and tend not to be in the poorer areas. Therefore it is questionable whether the benefit from extra capacity will be made available equally. Patients from more deprived areas will have longer distances to travel to private units, away from families and support networks.

83 – https://www.independent.co.uk/topic/ambulances
84 – https://www.independent.co.uk/topic/NHS
85 – https://www.independent.co.uk/topic/care-quality-commission
86 – https://www.theguardian.com/society/2020/jun/30/hospital-cleaners-coronavirus-pandemic-nhs-outsourcing
87 – https://www.kingsfund.org.uk/blog/2021/09/elective-backlog-deprivation-waiting-times

Falling standards and the perception of things getting worse is already driving thousands of patients towards the private sector and is confirmed by the results of an IPPR poll *(88)* and the think tank believes that if this continues then the two tier system that the NHS was designed to avoid could be brought far closer.

IPPR/YouGov polling shows that 31 per cent of adults in Britain - the equivalent of 16 million people - struggled to access the care they needed during the pandemic. Of these, almost one in eight (12 per cent) used some form of paid-for alternative and one in five considered doing so with this proportion rising for wealthier people.

Also one in six Britons (17 per cent) say they would 'go private' if they knew that they faced waiting longer than 18 weeks from referral to begin treatment on the NHS. That would mean 340,000 of the 2 million currently waiting longer than 18 weeks going private, 60% say they could not afford it and 10% who would not go private on principle.

Poor value

Analysis has shown that these deals have so far delivered poor value. Prior to the height of the first wave a deal was struck with independent Healthcare providers fearing that the NHS might be overwhelmed. Payments of around £400m a month were paid to private health companies to secure 100% access to their 8000 bed capacity. However leaked documents suggested that two-thirds of the private sector capacity that was block-purchased by NHS England was left unused *(89)* over the summer in 2020. The Centre for Health and the Public Interest estimated that on average there was only one COVID patient per day in the independent sector beds purchased, with the maximum daily usage being 67. Companies received substantial payments despite doing minimal NHS work, in effect helping to shore up the financial position of these companies during the pandemic. This poor value was picked up by the Treasury who blocked an extension to the deal and led to criticism from the Public Accounts Committee after they reviewed the arrangement.

In January 2022, a second deal with the independent hospital sector was proposed. Spire Healthcare became one of ten independent providers which signed a three-month deal to help maintain services if Omicron leads to unsustainable levels of hospitalisations or staff absences. The deal, agreed by Sajid Javid, the health secretary, means providers are paid to be on standby,

88 – https://www.ippr.org/news-and-media/press-releases/revealed-a-third-of-adults-struggled-to-access-nhs-during-pandemic-driving-many-to-private-healthcare

89 – https://www.hsj.co.uk/finance-and-efficiency/leaks-reveal-two-thirds-of-private-hospital-capacity-went-unused-by-nhs/7029000.article

with the NHS ordered to pay the private hospitals up to £270m, even though they may not treat any NHS patients in return.

Leaked letters showed that Amanda Pritchard, NHSE chief executive, raised doubts over the contract, which instructed the NHS to pay private hospitals £75m to £90m a month from NHS England funds for the next three months. Under the deal during a major surge capacity is released, but payments are likely to double to £175m a month. This contract could have led the NHS to pay independent hospitals up to £525m.

Pritchard warned that both scenarios would leave the NHS "exposed financially", and the arrangement creates "a material risk that the NHS pays for activity that is not performed".

She continued: "We have also agreed a 10 per cent premium to the standard NHS tariff for all work above the value of the MIG, and further premium additions for all more complex work (such as cancer) to incentivise the relevant ISPs to delivery activity that would not normally be done by ISPs because they deem it not profitable at standard NHS tariffs."

Pritchard also warned: "On a per bed basis this is significantly more expensive than the equivalent cost of an NHS site with much less certainty on the potential staffed capacity. There are also logistical challenges that need to be surmounted to facilitate the transfer and care of patients between NHS systems and around 150 IS sites across England."

The departure from the NHS tariff is an important precedent as it accepts that the private sector should be paid more for performing the same operation as NHS providers. If continued it would set the NHS in an underfunded second tier of hospital care and threaten their financial future.

The agreement also includes Practice Plus Group, Nuffield Health, Circle Health Group, Ramsay Health Care UK, Healthcare Management Trust, One Healthcare, Horder Healthcare, Aspen Healthcare and KIMS Hospital.

Future trends: 'Insourcing'

In the past the word 'insourcing' has been used to describe taking back in-house a service that has been outsourced, however NHS England, NHS Improvement, and the Department of Health and Social Care describe insourcing as "where an NHS organisation subcontracts medical services/procedures. It differs to locum supply in that the full end to end service is provided, not just staff. The supplier uses the NHS organisation's premises and equipment to deliver these services, however remote consultations are also available."

Under insourcing contracts companies conduct medical procedures, such as surgery and diagnostics, in NHS premises in downtimes, primarily the weekend, when the NHS is not using the premises. The staff they employ are generally full-time NHS employees who work on their rest days. This type of insourcing brings private companies into the heart of the NHS.

A national framework agreement is in place with NHS Shared Business Services *(90)* listing 18 companies. These companies have already gone through a competitive tendering procedure to be put on the list and can be used by trusts without additional contract tendering. The framework began back in 2018 and runs until September 2022. However, trusts are also using companies that are not listed on this framework.

The popularity of this approach has increased over the past few years and with any extra money for the NHS being funnelled into reducing the elective care waiting list, it is likely to keep on increasing.

The healthcare market analysts Mansfield Advisors *(91)* have noted that the NHS insourcing market is one of the fastest growing markets in private healthcare, in the 2019 financial year it was worth £44m, by FY2021 it had reached £95m, and the analysts predict it to rise to £139m in FY2022 and £295m in FY2024.

Companies active in the area and listed on the NHS SBS framework include Totally Healthcare, Eden Clinical Services, Gutcare, The Endoscopy Group, Medinet, and Alliance Health. Services being carried out by these companies include dermatology, general surgery, endoscopy, radiology, and a range of diagnostics for neurology and cardiology.

A major attraction of these contracts for cash-strapped hospital trusts is that the trusts get more procedures done per week to bring down the waiting lists, but at less than the cost of outsourcing the procedure to a private hospital. The insourcing companies are able to perform services for less than the NHS tariff, often at 20% less, because they don't have the fixed costs of their own hospital.

The popularity of insourcing with trusts also relates to how insourcing falls outside existing mechanisms for regulating staff labour. There is a cap on how much trusts can spend on agency workers and rates can only be increased beyond the cap to fill a shift if there is a patient safety issue, and it may be difficult to show there is an issue for routine elective care procedures.

Trusts save money by not having to employ bank staff (these are not subject to a price cap); employing bank staff can be expensive for the trusts as they may find themselves paying significantly more, particularly for nurses and allied health professionals.

90 – https://www.sbs.nhs.uk/article/17314/Insourcing-of-Clinical-Services

91 – https://www.laingbuissonevents.com/wp-content/uploads/2021/09/UK-Healthcare-Market-Review-Report-Launch.pdf

Health and care legislation: new procurement rules

The Health and Care Bill currently making its way through Parliament will change the way contracts for clinical services will be awarded. As widely publicised the bill does away with Section 75 of the Health and Social Care Act 2012, which requires clinical commissioning groups to put out to tender any contracts over a certain value.

However, although the bill will weaken the requirements on commissioners to run a competitive tender for NHS services, it will not eliminate the process entirely.

At present the commissioners of clinical services, such as NHS England, and NHS Clinical Commissioning Groups, are required to comply with both the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and, where the contract is valued at £663,540 or above, the Public Contracts Regulations 2015 ("PCR").

The new procurement regime, known as the provider selection regime, will apply to NHS England, the boards of Integrated Care Systems (ICS), and local authorities when they are arranging healthcare services as part of their public health functions. Given the timescales around the legislative process, the new regime is unlikely to come into force until 2023 at the earliest, although certain aspects, such as using social value as a criteria for awarding a contract are being pushed to be considered as soon as possible.

It should be noted that these reforms do not apply to the procurement of non-clinical services by these commissioners, such as professional services or clinical consumables, which will remain subject to the Public Contract Regulations 2015 rules, until these are replaced by Cabinet Office procurement reforms.

A consultation on the changes began in December 2020 and the government responded to the consultation in December 2021.

So what will the new regime look like?

Well the major change under the new provider selection regime will be that organisations will be allowed to roll over current contracts or appoint the most "suitable provider" based on key criteria: quality (safety, effectiveness and experience) and innovation; value; collaboration and integration; access, inequalities and choice; and service sustainability and social value. These all need to be considered although they can be prioritised to differing degrees.

"Although many of the changes have been welcomed, in particular those that will lead to a reduction in the number of competitive tenders, issues remain, including the lack of an independent review body and problems with transparency... The only independent way of challenging a decision will be by seeking a judicial review."

Commissioners will be faced with three general circumstances when awarding contracts as follows:

- Seeking the continuation of existing arrangements with their provider, for example where there is no alternative provision (e.g. 999 emergency ambulance services) or the incumbent provider(s) is doing a good job when judged against the key criteria and the service is not changing.
- Selecting the most suitable provider when a service is new/changing substantially but a competitive process is not appropriate. In this situation, commissioners will have to apply the key criteria and then, if they believe that one or more providers are the most suitable, they may award the contract to that provider(s) without conducting a competitive process.
- Selecting a provider by running a competitive procurement process, such as in situations with a new or greatly altered service where there is no obvious candidate capable or willing to take on the contract, or where the incumbent provider of a service has not proved to be suitable nor fulfil the criteria and there is no obvious candidate.

A notable change in the new provider selection regime is an emphasis on social value when awarding contracts; this criteria could be introduced from as early as April *(92)*. It will mean factors such as local employment and decarbonisation will need to be considered when awarding contracts.

There will also be the possibility for exclusion of a supplier based on past performance *(93)*, but only where that performance "was so poor as to create risks to the delivery of any future public contracts".

Another change will be the wording of procurement rules so that contracts can be awarded based on the "most advantageous tender" rather than the "most economically advantageous tender" as procurement rules currently have it.

Although many of the changes have been welcomed, in particular those that will lead to a reduction in the number of competitive tenders, issues remain, including the lack of an independent review body and problems with transparency.

During the consultation process, the lack of an independent review system was highlighted by many respondents. The new regime does allow "representations" to be made to commissioners, such as ICS boards, if there are objections to or concern over a contract award, but no independent authority will be put in place to deal with complaints. The only independent way of challenging a decision will be by seeking a judicial review.

Despite this criticism in the consultation, the government is firmly against the idea of an independent contracting authority review in the event of a dispute, due, according to its response in December 2021, "the cost and resource implications involved in making this truly independent and effective".

A new unit to be known as the Procurement Review Unit (PRU), sitting within the Cabinet Office, will be put in place, but this will only investigate cases of poor policy and practice reported by suppliers. It will make informal recommendations, but not target specific procurement decisions (for example, the unit could not recommend a specific contract should be awarded to a particular supplier).

The issue of transparency is also of concern. The British Medical Association has warned that the changes could "allow contracts to be awarded to private providers without proper scrutiny or transparency". In reply to concerns in its consultation, the government notes that "procedural obligations at each stage of the procurement process setting out more explicit publication obligations that will provide clarity to contracting authorities on exactly what they need to publish." Though, as the BMA has noted, the transparency arrangements will need to be "robust" if "the cronyism that has unfortunately been a prominent feature of procurement during the Covid-19 pandemic" is to be avoided.

Finally one of the biggest disappointments of the changes to procurement is the fact that the NHS has not been made the preferred provider of NHS services. Both UNISON and the BMA have noted that the issues seen in contract awards during the pandemic, such as cronyism and corruption, should have led to the NHS being established as the preferred provider of NHS services.

92 – https://www.hsj.co.uk/service-design/mandatory-social-value-weighting-of-10pc-for-all-nhs-procurement/7030687.article
93 – https://www.hsj.co.uk/finance-and-efficiency/new-procurement-rules-would-bar-poor-performing-suppliers/7031511.article