

BMA

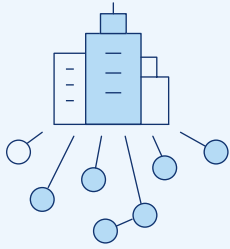
Outsourced: the role of the independent sector in the NHS



Contents

Executive Summary	2
Introduction.....	3
Context.....	4
More private sector contracts are being used to help tackle NHS waiting lists	4
How we got here	5
ISPs have played a growing role in the delivery of elective procedures	5
Non-NHS provider spend has increased since the 2012 Health and Social Care Act.....	7
Spending on ISPs specifically increased in 2020/21 due to the pandemic	8
Discussion and policy implications: the future relationship between the independent sector and the NHS.....	8
The elective recovery plan will increase current levels of outsourcing with serious longer-term risks for the NHS.....	8
Demand for self-funded care in the independent sector is increasing.....	9
The Health and Care bill risks opening the door to further outsourcing.....	10
BMA Views.....	11
There are legitimate concerns over transparency and whether the NHS is getting value for money	12
Purchasing 'extra' capacity from the independent sector may have serious workforce implications	12
Outsourcing contracts to ISPs will potentially fragment health services further.....	13
There are concerns around the lack of intensive care facilities in ISP hospitals	13
'Cherry picking' of high volume, low complexity patients risks undermining the NHS.....	14
Outsourcing procedures to ISP hospitals reduces training opportunities.....	15
The uneven distribution of ISP capacity across England could potentially widen existing health inequalities	15
Recommendations.....	17
1 – NHS capacity must be increased in the medium to long-term.....	17
2 – A viable exit strategy is needed from Government to reduce the role of ISPs in the delivery of NHS-funded services.....	17
3 – The Health and Care Bill must be amended to safeguard the NHS from further outsourcing.....	19
Appendix 1:.....	20

Executive Summary



The BMA recognises the need to utilise all available capacity to address vast NHS waiting lists, however, we are concerned that the UK Government's plans – and namely its recently published elective recovery plan – risk embedding a longer-term trend of outsourcing NHS contracts and funding to independent sector providers (ISPs) in England. We firmly believe that any arrangements with the independent sector should be time-limited and not a replacement for a credible longer-term plan to increase NHS capacity.

This report looks at the NHS in England where pro-marketisation reforms and increased outsourcing of NHS clinical services has been a long-standing issue.

The recently published elective recovery plan comes at a time when the English NHS is experiencing some of the most severe pressures in its 70-year history. A decade of under-investment and inadequate system planning has left the NHS with crippling workforce and bed shortages, and therefore, no spare capacity to tackle the NHS elective waiting lists which existed before the COVID-19 pandemic and have been ever-expanding since.

Consequently, it is important to utilise all available capacity – including the short-term use of ISPs – to address waiting lists and ensure patients receive the treatment they need with as little delay as possible. However, it is likely that the Government's proposals will significantly increase the current levels of outsourcing and resourcing made available to ISPs, rather than sustainably increasing NHS capacity.

The BMA has clear and long-standing policy opposing outsourcing of NHS frontline clinical services on the basis that greater use of ISPs by the NHS could lead to a decline in standards and poor value for money, fragmentation and destabilisation of services putting staff and patients at risk.

- Our analysis has illustrated a worrying trend in independent sector provision of care:
- Public spending on ISP contracts is already high and has been growing year on year. Spend on ISPs was £13.8 billion 2020-21, £2 billion more than the £11.8 billion spent in the previous year.
 - ISPs delivered 5.2% of all NHS-funded elective activity in 2020-21, compared to just 0.02% in 2003-04.

As the NHS looks to address its ever-growing waiting lists following the COVID-19 pandemic, it is likely that an increasing share of public [funds](#) will be spent on purchasing health care services from the independent sector. This is particularly concerning given the lack of transparency of ISP contracts and the potential for public resources to be wasted.

Increasing uptake of NHS-funded care by the independent sector also comes with potential implications for doctors, patients and the NHS more broadly. The medical profession is concerned that the availability of NHS staff in NHS hospitals, the funding and sustainability of NHS services and the scope and quality of doctors' training will all significantly worsen under the renewed outsourcing arrangements with independent sector hospitals.

In view of the Government's policy proposals, the BMA is calling for:

- A substantial increase in NHS resource and capacity, including an increase in beds and workforce numbers
- A viable exit strategy to reduce the role of ISPs in the delivery of NHS-funded services
- The Health and Care Bill to be amended to safeguard the NHS of ISP involvement

Introduction

The BMA has long-standing concerns about the increasing levels of independent sector provision of NHS-funded care and has consistently opposed the outsourcing of NHS contracts, which waste vital NHS time and money, fragment services, and encourage competition over collaboration. We therefore believe that a fully resourced, publicly funded, publicly provided NHS that is free at the point of care is essential to the health of the population.

The Government's pandemic response and elective recovery plan heavily reflect its commitment to further embedding the independent sector into the fabric of health service delivery. This commitment was reiterated by the Health and Social Care Secretary in his [speech](#) on the 8th March 2022 where he presented his plans for NHS reform.

Years of NHS under-resourcing meant that the pandemic necessitated unprecedented arrangements with the independent sector to bolster capacity. ISPs (independent sector providers) were swiftly [handed](#) key public health duties in important areas for example Test and Trace. Critically, ISPs were also contracted to continue routine elective care and provide additional capacity to support the pandemic response – something which the Government intends to continue in the longer term as the NHS seeks to tackle enormous backlogs of care.

At the height of pandemic, enlisting ISPs to support overstretched NHS services was needed to safeguard patient care, however, this should have been done transparently with clearly defined targets. Independent sector contracting fell short when it came to delivering NHS patient care. This is evidenced by the underutilisation of beds and the negotiated [revisions](#) to the COVID contracts – a focus of which was to ensure value for taxpayers' money.

While the Government has sought to justify the increased use of independent sector capacity with the exceptional circumstances of the pandemic, the wide-scale outsourcing of NHS services and 'partnerships' forged with ISPs throughout the pandemic form part of a historic trend involving a suite of Government market reforms that have gradually but comprehensively opened up the English NHS to privatisation.

The Health and Care Bill has generated extensive discussion about the role of ISPs in the NHS, prompting debate about what the health service will look like in the future. This has included widespread concern – as voiced by the BMA and its members – that the Government's reforms could further entrench the involvement of ISPs in the NHS.

Our new research set out in this report examines the extent of ISP involvement within the NHS and what this means for doctors, patients and the health system as a whole. This sits alongside a wider examination of the role and reach of the independent sector within the health service in England and how the changing policy landscape might alter it, as well as our recommendations for how the NHS should be at the heart of its own recovery.

Context

More private sector contracts are being used to help tackle NHS waiting lists

With trusts now under increasing pressure to reduce elective care waiting lists and the wider 'hidden' backlog of care,¹ there is renewed focus on the independent sector's role to increase NHS capacity and relieve pressure on overstretched services. This has been made clear in the Government's elective recovery plan and presents the potential for a bigger, long-term role for the independent sector in both the delivery and planning of healthcare services.

The plan proposes to significantly increase the use of the independent sector through a range of ways including the expansion of patient choice, long-term contracts and partnerships with ISPs, and the development of a payment regime to incentivise increased activity. As well as bolstering NHS capacity through the delivery of high-volume, low complexity procedures, the elective care strategy states that ISPs will sit on elective care boards within each ICS to support the planning and delivery of a system-wide strategy for elective recovery based on local need and operational challenges. This raises serious concerns about ISPs' potential influence over NHS commissioning decisions at system level.

Among the initiatives to help clear the elective care waiting lists is the four-year 'National Increasing Capacity [Framework](#)'. This is an agreement that could see ICSs and NHS trusts spend up to £2.5 billion a year procuring elective activity from a pre-approved list of ISPs. These funds represent almost double the amount spent on contracts with independent sector hospitals in 2018 and 2019.

In addition to this framework, the Government signed a three-month [contract](#) (until 31 March 2022) with ISPs to reserve a large number of hospital beds to be used for urgent NHS care in the event of another COVID-19 surge. This is said to provide vital segregated, safe elective capacity to enable the continuation of surgery. Without a sustainable, long-term increase in NHS capacity, short-term measures of this kind are likely to set a costly precedent for taxpayers in terms of how future health emergencies are managed.

These arrangements succeed the first COVID contracts in 2020 that block-purchased the entire operational capacity of 26 ISP hospitals in England. In return, the NHS received access to thousands of additional beds and equipment to treat both COVID-19 patients and deliver urgent elective care and cancer treatment. However, the extent to which this capacity was used remains [unclear](#), and, consequently, there have been widespread concerns around the enormous levels of funds allocated to these ISP hospitals.

¹ The backlog in secondary care consists of the care that the NHS would normally have delivered but which was disrupted as COVID-19 impacted service delivery. This includes patients who have not yet presented to their GP to seek a referral for symptoms due to concerns of burdening the health services or fears around COVID-19 infection; patients who had procedures cancelled; patients who have had referrals delayed, cancelled or refused due to a lack of capacity.

How we got here

The health system is currently facing an extremely precarious moment in its history. Inadequate planning and a decade of sustained [under-investment](#) have resulted in acute staffing shortages across primary and secondary care, estates and equipment that are unfit for purpose, and significant bed shortages with patients forced to endure lengthening waits for treatment.

Existing system and workforce [pressures](#) compounded by the COVID-19 pandemic have consequently created a vast backlog of elective care. Waiting lists are now at a record high of six million – 311,000 of whom have been waiting for longer than a year, a 212-fold increase on the number waiting longer than a year compared to December 2019, before the pandemic. Meanwhile, we [estimate](#) that since the outset of the pandemic there have been 4.29 million fewer elective procedures and 29.40 million fewer outpatient attendances than would have been expected in the same period pre-pandemic.



Source: BMA analysis of NHS England Consultant-led Referral to Treatment Waiting Times statistics

Tackling these waiting lists hinges on the NHS workforce. Yet the NHS is in the midst of a chronic workforce crisis – insufficient workforce planning has resulted in a cycle of mounting pressures, poor staff retention and stubbornly high vacancies.

Official estimates of vacancies indicate that as of December 2021, almost 110,000 posts in secondary care remain unfilled, more than 8,200 of which are medical posts. However, we know that this is likely an underestimation – our [analysis](#) shows that England needs around 46,300 additional FTE (full-time equivalent) doctors simply to put us on an equivalent standing with today's OECD (Organisation for Economic Co-operation and Development) EU average of 3.7 doctors per 1,000 people.

Compounding this problem is the fact the UK has far fewer hospital beds per 1,000 people than any other comparable health system. The average number of beds per 1,000 people in OECD EU nations is 4.6, but the UK has just 2.4. Germany, by contrast, has 7.9. With a 10% reduction in overnight general and acute beds between 2011-12 to 2019-20, bed occupancy rates in England regularly surpass 85% – the level hospital [leaders](#) broadly see as the point beyond which safety and efficiency are at risk, and eliminating surge capacity.

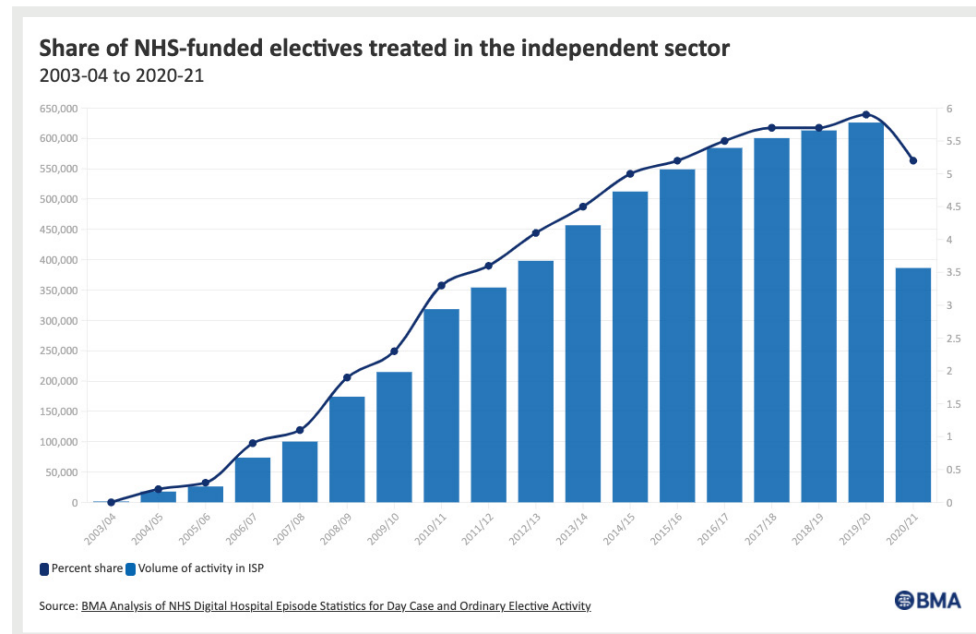
ISPs have played a growing role in the delivery of elective procedures

The involvement of ISPs in the provision of NHS services in England is by no means a new phenomenon. In the decades leading up to the pandemic, growth in ISP provision of NHS care has been precipitated by a range of different factors, not least a desire for additional capacity to augment existing NHS services, increasing emphasis on the widening of patient choice and, most controversially, political drives to introduce competition within the health [service](#).

Ambitious elective care targets – such as those linked to the NHS ERF (Elective Recovery Fund) or the EAP (Elective Accelerators Programme) may also, more recently, have contributed to the increase in ISP delivery of NHS care. The ERF and the EAP have allowed ICSs to draw down additional funding if they deliver 95% and 120% of pre-pandemic activity respectively. This means that to access more funding ICSs and NHS services within them have been expected to essentially provide a pre-Covid service during the pandemic. Consequently, ICSs have looked to maximise their elective activity, leading some to increase provision of NHS-funded care in the independent sector.

Successive Government market reforms were, at least in part, made in response to lengthy waiting lists and delays in patients receiving elective care – an issue the pandemic has brought to the forefront of policy-makers minds once again.

The contribution of ISPs in delivering NHS-funded care has as a result over time rapidly grown from a small base. Our analysis suggests that ISPs provided approximately 386,800 NHS-funded elective episodes in 2020-21 – or approximately 5.2% of all NHS elective activity. This is 258 times the 1,500 episodes (0.02% of all NHS elective activity) delivered by ISPs in 2003-04, the year in which ISTCs (Independent Sector Treatment Centres) were introduced and comparable records began.



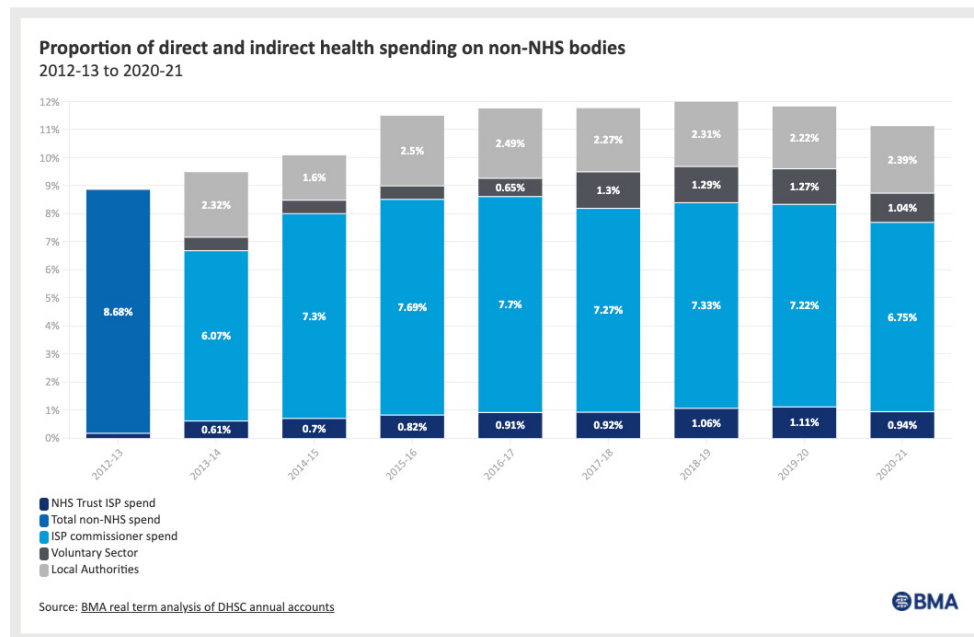
It is important to note that while the publicly provided NHS remains the dominant provider of healthcare in England, ISPs have played an increasing role in providing routine NHS-funded procedures such as cataract surgery or hip and knee operations.² According to [research](#) by the Royal College of Ophthalmologists, in 2021 almost half (46%) of all NHS funded cataract procedures were carried out by the independent sector. By contrast, 11% were delivered in the independent sector just five years prior in 2016. This [trend](#) has also been observed across trauma and orthopaedics. In 2016-17, approximately 29% of knee and 20% of hip replacements were delivered by ISPs, up from 20% and 14% respectively in 2012-13.

Emerging [evidence](#) suggests that, since the onset of the pandemic, the range of procedures delivered by the independent sector in London has expanded to include complex treatments such as cancer and cardiac care. This development has revealed the extent to which NHS hospitals have become reliant on outsourcing to reduce the level of pent-up demand for cancer treatment and other services.

² NHS Digital Health Episode Statistics provides data on the overall volume of elective activity carried out in the independent sector from 2003 onwards. Procedure-level data is however not publicly available, making it challenging to compare treatments in the same time frame.

Non-NHS provider spend has increased since the 2012 Health and Social Care Act

Spending on independent sector providers and other non-NHS providers is highly complicated and requires a degree of [interpretation](#). The BMA has repeatedly [called](#) for greater clarity and consistency in the collection of independent sector spending data to enable more accurate analysis of the extent of privatisation within the NHS in England. There are broadly two routes through which spending occurs – either through direct purchase by NHS commissioners from non-NHS providers or indirect purchase of elective care from ISPs by NHS trusts. Below we discuss aggregate direct spend on non-NHS providers; indirect spend from ISPs by NHS trusts; and combined direct and indirect ISP spend.



While most healthcare services are purchased from NHS providers, as set out above non-NHS providers have a substantial and growing role in delivering healthcare and support services, evidenced by the public funding they have increasingly secured. The National Health Service and Community Act of 1990 introduced 'internal markets' into the NHS. However, the 2012 Health and Social Care Act saw the expansion of alternative providers into this healthcare 'market', with a larger share of public sector funds transferred onto the balance sheets of non-NHS providers.

Non-NHS providers include independent sector providers, the voluntary sector as well as local authorities, however [evidence](#) suggests that a proportion of local authority spend itself is allocated to ISPs. It is therefore important to look beyond ISPs figures as these, alone, are an underestimation of the total sums spent on the independent sector. Reporting on ISPs specifically is also difficult given that prior to 2013-14, non-NHS provider spend is reported in aggregate, and not broken down to specific ISP, local authority or voluntary sector spend.

Cumulatively, a total of £125 billion has been allocated directly to non-NHS providers since 2012-13. Although the exact figures are difficult to define, we estimate that direct and indirect spend on non-NHS providers has increased by more than two thirds (70%) since 2012-13, from £10.8 billion to £18.3 billion (after adjusting for inflation).³ By contrast, the total DHSC RDEL spend (planned day-to-day health department spend) increased by less than half (42%).

³ Figures are adjusted for inflation through this report

Consequently, the proportion of spend allocated to non-NHS providers has increased from 8.7% of the DHSC's RDEL budget in 2012-13 to 11.1% in 2021-21 (Appendix 1). As a total proportion of overall public day-to-day spending, this represents a significant jump from 3.2% and 4.6% in that same time period.

When looking at total spend on ISPs only,⁴ direct and indirect, the NHS spent approximately £13.8⁵ billion in 2020-21. There are no comparative figures for 2012-13, as we cannot break down pre 2013-14 non-provider spend. However, this is an increase from 2013-14, where total spend on ISPs was £8.4 billion.

Within these figures, DHSC accounts also tell us about the indirect purchase of acute elective care from ISP hospitals by NHS trusts. This is one of the fastest growing areas of health expenditure, with a notable increase in [spending](#) in the years after the 2012 Act took effect. While the total DHSC RDEL has not even doubled between 2012-13 to 2020-21 (42% increase), NHS trust spend on ISPs has increased much more, from over £220 million to £1.7 billion, in the same time frame (an increase of 559%).

Spending on ISPs specifically increased in 2020/21 due to the pandemic

Spend on ISPs was £2 billion higher in 2020-21 compared to the previous year, where spend was £11.8 billion. The significant increase in ISP spending during the pandemic reflects the historic lack of NHS funding which led the Government to contract with ISPs to bolster NHS capacity.

Given the Government's explicit intention to use ISPs in the recovery of elective services and the emphasis on expanding patient choice in both the ERP and the Secretary of State's March 8th speech, it is likely that an increasing share of public [funds](#) will be spent on purchasing health care services from the independent sector going forward.

4 This considers ISP spend as defined by DHSC accounts and does not factor spend on local authority or voluntary sector services. Therefore, it is lower than the £18.3bn direct spend figure above that includes local authority and voluntary sector services.

5 In their most recent report, the NAO suggests that contracts were handed to both the public and private sector to deliver Test and Trace – however this did not include a breakdown on spend. It is unclear whether a proportion of the 13.8 billion spent on ISPs was allocated to Test and Trace. Rather, DHSC accounts for 2020-21 have separately indicated that £11 billion was allocated to Test and Trace.

Discussion and policy implications: the future relationship between the independent sector and the NHS

As the NHS looks both to address enormous elective waiting lists exacerbated by the pandemic and towards the changing legislative landscape set out in the Health and Care Bill, the debate about what role ISPs should play in the delivery of NHS-funded services is once again at the forefront. The direction of travel being taken by government is clear and reaffirms historic and new commitments to embed the independent sector in the delivery of NHS frontline clinical services.

The elective recovery plan will increase current levels of outsourcing with serious longer-term risks for the NHS

The elective recovery plan sets out how the NHS is expected to improve its elective care performance over the next three years. It expands existing programmes as well as introduces new targets and policies, with a view to ensuring elective services recover rapidly. The plan focuses on four key areas of delivery, including increasing health service capacity alongside the independent sector.

While we recognise the need to utilise all available capacity to tackle elective care waiting lists, we have serious concerns about the increasing reliance on the independent sector to deliver NHS-funded elective care. The priority must be to increase investment in long-term NHS infrastructure and capacity to prevent further backlogs of care in the future, not to direct that taxpayer-funded investment into the independent sector and ultimately shareholders' pockets.

The plan also risks embedding ISP provision of elective NHS care in the longer-term and potentially beyond the 2025 target for elective recovery. This threatens to undermine NHS planning, finances, and staff training if certain surgeries – namely high volume, low complexity procedures – are no longer performed in the NHS. These concerns have been [echoed](#) by nearly 200 ophthalmologists who have warned that plans to outsource more routine procedures (e.g., cataract surgery) to independent hospitals will reduce the number of doctors working in the NHS performing these procedures. This would have significant implications for the future workforce pipeline as a result of the loss of NHS training opportunities in these procedures, with risks for patient safety. This would also correspondingly lower the number of complex procedures delivered, putting the most vulnerable at risk.

Separately, the lack of detail regarding the terms of ISP involvement in elective recovery is concerning, particularly in relation to possible incentives to increase activity, transparency of contracts, and how the value for money of ISP provision of NHS care will be assessed.

Likewise, the prospect of ISPs sitting on newly established ICS Elective Care Boards, which will plan and deliver local strategies for elective care recovery, is alarming. The use of NHS resources should be determined by NHS leaders and based on patient need. ISPs – which will benefit financially from their role in tackling NHS waiting lists – should not be able to directly influence local decision making on elective recovery.

Demand for self-funded care in the independent sector is increasing

The independent sector is facing increasing demand from both NHS waiting lists and patients seeking private treatment. Unmet need rapidly accumulating across the NHS has afforded ISPs a continuous stream of public funds that will continue into the foreseeable future. In theory, ISPs can only stand to benefit from an increase in Government spending – the sector has long-relied on income generated through NHS-funded treatment, with public funds accounting for [31%](#) of private sector revenues in 2019.

However, in practice, the extent to which independent sector hospitals will be able to take on NHS waiting list initiatives going forward is unclear. Mounting [evidence](#) shows that longer waits for NHS treatment are driving more patients to seek private healthcare. In the last year, this has led to a dramatic growth in the self-pay market which has meant that ISP capacity available to the NHS is potentially diminishing.

A YouGov [survey](#) commissioned by the PHIN (Private Healthcare Information Network) has found that that over one in five people are more likely to self-finance their care due to concerns over restricted NHS access. Indeed, a report published by health data firm [Laing Buisson](#) (April 2021) found growth in all private providers across the self-pay market, with 52% of those surveyed anticipating a 10-15% growth over the next three years.



NHS-funded activity carried out by ISPs is further constrained by the backlog of private patients who were unable to access treatment during the 2020 block-booking arrangements. A BMA survey (September 2021)⁶ of doctors engaged in private practice found that under these [arrangements](#), 60% of private practice respondents were unable to provide care to their private patients at the time. Approximately 25% reported private patients presented later than they should have – citing NHS bed reservation and subsequent limited capacity as the reason.

⁶ The BMA Private Practice Survey was launched on 23 September 2021 and closed on 18 October. It was largely open to doctors working in private practice for some or all of their time, with 1,113 responses received.

The Health and Care Bill risks opening the door to further outsourcing

The Health and Care Bill has been promoted in part as a means of reversing existing models of competition, to prioritise collaboration and integration within the NHS. The BMA has been clear that the Health and Care Bill is [the wrong bill at the wrong time](#) and is actively campaigning for it to be significantly and urgently amended to safeguard the NHS.

Health and Care Bill 

WRONG BILL WRONG TIME 

The NHS is still under huge pressure from the pandemic, it is not the right time for the NHS or for patient care for the biggest reorganisation in a decade

The bill:

- says nothing about ensuring that the NHS has the doctors, nurses and healthcare workers it needs
- fails to empower clinical leadership
- risks a new wave of unaccountable private sector contracting and a seat on new decision-making boards for private sector bodies
- gives politicians greater powers to interfere in operational NHS decision-making

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The Bill seeks to achieve this by removing Section 75 of the 2012 Health and Social Care Act, which mandates competitive tendering for contracts worth more than £615,278, and replacing it with a new Provider Selection Regime, which would give commissioners greater control over how they award contracts. Under this regime, commissioners would be able to award or renew contracts without the need for a competitive tendering process.

While we have been highly critical of mandated competition within the NHS, we are concerned that the new Provider Selection Regime, rather than ending marketisation or the fragmentation of services caused by competition, could in practice lead to unaccountable outsourcing of contracts. By allowing contracts to be potentially handed to ISPs without due scrutiny, there is a risk that this new approach may lock-in or even increase the proportion of NHS services that are delivered by ISPs. This will hinder rather than improve collaboration and integration of NHS services and is one of the reasons why the BMA is opposed to the Bill and has campaigned for it to be significantly amended.

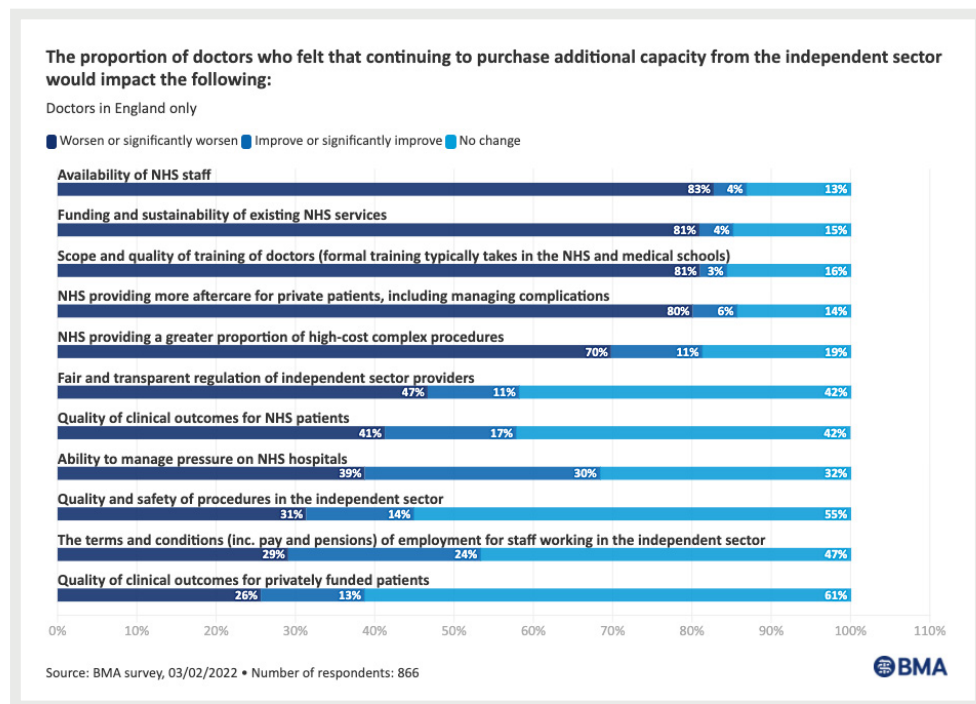
As a result, we believe that the Bill must be amended to make the NHS the default option for NHS services. This would mean that NHS providers would be the first choice for NHS contracts, with a view to supporting their long-term financial security, the continuity of patient care, and the development of collaborative and integrated models of care.

Unless outsourcing is greatly reduced, much of the fragmentation created by the 2012 Health and Social Care Act will remain an impediment to genuinely integrated care.

BMA Views

The growing role of ISPs in providing NHS services has long concerned the medical profession. Our [research](#) indicates that doctors are concerned that it could lead to the destabilisation and fragmentation of NHS services. Our members have also expressed [concern](#) that ISP provision of services often represents worse value for money for the NHS and that the care provided by ISPs is of worse quality.

In February 2022, we surveyed our members to better understand their views on the outsourcing arrangements in place with ISP hospitals, and the potential trade-offs or implications this may have on doctors, patients and the NHS more broadly.



Our research has found that doctors are largely divided as to whether purchasing additional capacity from the independent sector would improve the ability to manage pressures on NHS hospitals. Two in five doctors (39%) feel that ISP contracting will significantly worsen the ability to manage NHS pressures, compared to just 30% who believe it would improve.

Concerns highlighted include the availability of NHS staff (83%), as a result of the existing limited pool of staff taking on additional work in the independent sector; the funding and sustainability of NHS services (81%) if certain more profitable services are ‘creamed off’; the scope and quality of doctors’ training (81%), given independent sector providers are under no obligation to train staff. There are also concerns around the fair and transparent regulation of ISPs (47%) and the potential for the quality of clinical outcomes for NHS patients to worsen (41%) in ISP settings, which often do not have access to emergency care for example or the resources available in NHS hospitals.

While not strictly comparable to previous BMA surveys due to a change in wording, these figures indicate that independent sector provision continues to be a large cause of concern for doctors.

There are legitimate concerns over transparency and whether the NHS is getting value for money

Greater use of ISPs by the NHS could also lead to poor value for money. This is something we have consistently raised concerns about, and something which the pandemic has largely confirmed. During the pandemic a high number of contracts have been outsourced to inappropriate and ineffective ISPs under emergency procedures whilst bypassing normal tendering processes, public scrutiny, and, perhaps most importantly, without demonstrating value for taxpayers' money.

The significant funding allocated to, and subsequent under-utilisation of ISP hospital capacity paid for during the pandemic is a case in point. Notably, there has been a lack of transparency around how much was spent by the NHS on purchasing services from these providers without a clear indication of what the NHS received in return – two years have passed since the contracts were signed and the public still do not have sight of these. It is also notable that there have been attempts to avoid scrutiny of this spend. In August 2020, we submitted an FOI request to NHS England asking for detailed information on the level of activity carried out in ISP hospitals. However, this request was not fulfilled.

Nevertheless, there is considerable [evidence](#) that this agreement has cost the Government a significant amount and has proven to be a serious misuse of taxpayers' money – leaked documents suggest two-thirds of private hospital capacity went unused in the summer of 2020 while the CHPI (Centre for Health and the Public Interest) [estimated](#) that on average there was one COVID patient per day in the ISP beds, with a maximum of 67 per day. Concerningly, there have been no penalties for failure to meet the terms of this or any other COVID contract.

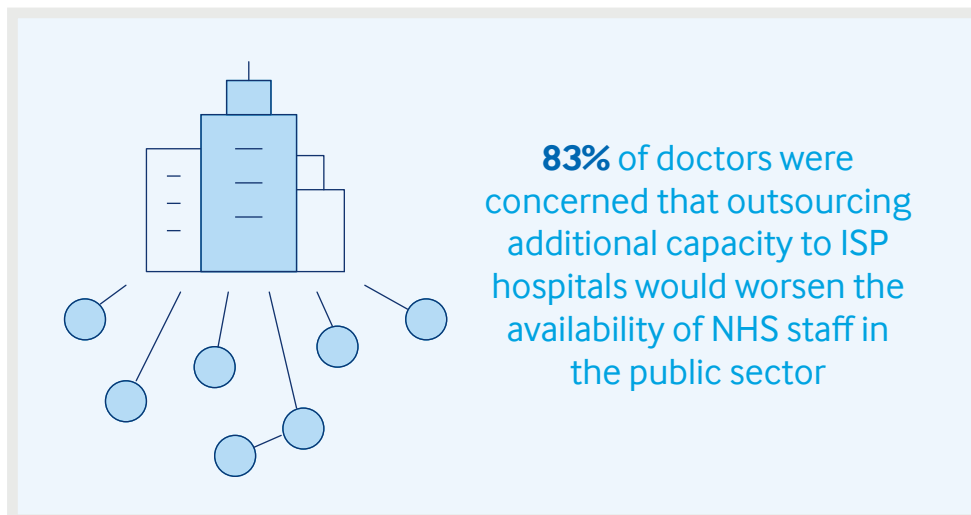
At a time of increasing healthcare budgets funded by hard-earned taxpayers' money, we believe that public scrutiny of ISP contracts is even more important given the increasing number of outsourcing agreements and funds allocated to the independent sector and the strong potential for poor outcomes and value for money.

Purchasing 'extra' capacity from the independent sector may have serious workforce implications

With the Government banking on private hospital sector capacity to support the NHS, there are questions to be asked about how much 'additional' capacity can be provided given that private hospitals across the UK largely rely on NHS consultants who carry out additional work in their free time. This was made all too clear in the first round of COVID [contracts](#), which saw the NHS largely gain facilities rather than the workforce to run them.

The more recent three-month surge arrangements running up to the end of March 2022 with the private sector have prompted renewed concern about what 'additional' capacity means in practice. Equally, it is notable that senior NHS leaders have publicly [expressed](#) doubts as to whether this deal represents good use of public money and if the private sector can deliver. In part, because 'the independent sector is not typically used for medical bed capacity and its staffing model does not easily support significant 7/7 staffed bed capacity' meaning increased use of private sector capacity, such as beds, would risk diverting staff away from NHS hospitals.

This concern, as expressed above, stood out strongly in our survey of BMA members (February 2022) with respondents clearly articulating their apprehension that the purchase of additional capacity from the independent sector would worsen the availability of NHS staff in the public sector. Given the limited pool of staff across the private and public sector, the advantage of procuring extra beds from the private sector must be carefully balanced with the need to maintain adequate and safe staffing levels in the NHS.



Indeed, the ongoing increase in the delivery of NHS services by ISPs, and the sharp increase in patients opting for “self-pay” may have serious implications for the medical workforce within the NHS. This is compounded by the fact that there is an undersupply of doctors to meet the current levels of demand facing the NHS. Also, given that the private and public sector largely draw on the same limited workforce, doctors will be expected to work harder with potential consequences on their mental [wellbeing](#).

In a similar vein, increased demand in self-funded treatment may lead to the expansion of the private hospital medical labour market which currently draws upon a sizeable number of NHS-trained doctors.

Outsourcing contracts to ISPs will potentially fragment health services further

Health and care services are increasingly expected to collaborate and integrate across traditional boundaries and siloes, as set out most recently in the UK Government’s [integration white paper](#).

In order for this to work, however, the provision of healthcare must be well-coordinated to ensure continuity of care and that patient needs are appropriately met. Outsourcing contracts to ISPs does not achieve this. Rather, it risks continually fragmenting services and disjointing patient care, by dividing services across a range of competing providers.

Fragmentation of NHS services [worsened](#) under the 2012 Act, which embedded market principles in the NHS further, enforced competition and led to adversarial relationships between local [partners](#).

There are concerns around a lack of intensive care facilities in ISP hospitals

The BMA has consistently [highlighted](#) safety in independent sector hospitals as a concern for doctors, with most private hospitals lacking intensive care facilities, post-operative emergency care, crash teams or multiple specialists to deal with patient complications when they arise. Patients are transferred to an NHS hospital when their condition deteriorates and requires prompt assessment and management. In the year up to June 2021, a [total](#) of 518 patients⁷ in England were transferred to emergency NHS care following treatment in independent hospitals.

Given the increasing number of procedures delivered by the independent sector, and the current pressures facing critical care units in the NHS, it is likely that the NHS will have limited capacity to act as a safety net when complications occur in the independent sector.

⁷ While this represents a small percentage of the overall number of NHS patients treated in the independent sector, it is important to note that any transfers to NHS ICUs makes a huge impact on the service given that the NHS has no spare capacity

Indeed, the large majority (80%) of doctors⁸ believe that under the recently announced outsourcing arrangements, it is likely that the NHS will be required to provide more aftercare for patients receiving hospital treatment in independent sector facilities.

The emergency transfer of elective patients back to NHS hospitals can also significantly impact NHS ICU capacity and distort health system prioritisation and planning. The reduction in NHS intensive care bed numbers across recent years has, in part, led to the postponement of surgeries that require patients to be booked into ICUs for post-operative care. This is compounded by an increasing number of patients being urgently admitted into NHS ICUs with complications that cannot be handled in the independent sector. Beyond the immediate workload implications of using NHS staff and services to address these problems, doctors are also concerned that postponed NHS activity may have been urgent while transfers from ISP hospitals are largely elective cases that could have safely waited for care.

Independent sector hospitals may also not be appropriately equipped to care for NHS patients at greater risk, such as elderly patients or those with co-morbidities. Any movement of patients to ISP settings to fulfil elective waiting lists should therefore be subject to a thorough risk assessment that ensures all patients are safely cared for.

'Cherry picking' of high volume, low complexity patients risks undermining the NHS

The BMA is concerned that the Government's commitment to reducing elective waiting lists and waiting times will further accelerate the shift towards independent sector provision of routine operations, such as cataract surgery, leaving complex, and more costly operations to the NHS. Indeed, seven in 10 doctors who responded to our survey answered that outsourcing arrangements with ISP hospitals will lead to the NHS providing a greater proportion of high-cost complex procedures.

'Cherry-picking' is, in part, a direct result of independent sector providers not having facilities for emergency care, or staffing arrangements to deal with complex patients.

There are fundamental concerns that the outsourcing of simple procedures will compromise both the clinical and financial viability of NHS services, that it will consequently intensify working conditions and increase pressure on staff. These pressures extend to GPs, who will be relied on to provide care and support to patients after they are discharged from ISP hospitals, for post-operative infections for example, and subsequently refer patients to NHS facilities.



7 in ten doctors told us that outsourcing will leave the NHS providing a greater proportion of high-cost, complex cases

'Cherry-picking' of routine procedures is also observed with a number of 'insourcing' companies.⁹ These independent sector companies employ theatre staff to treat NHS elective patients in NHS settings during low utilisation periods, primarily the weekend or evenings. Insourcing companies typically use their own anaesthetists and theatre staff while the host Trust provides surgical and nursing staff to ensure they follow their procedures.

This approach to increasing elective activity has become more and more prevalent in recent years.¹⁰ With the advent of the ERP and financial incentives to increase NHS elective activity, such as the ERF, the use of insourcing companies is likely to increase further.

As with outsourcing arrangements, there are both immediate and long-term implications of bringing in independent sector companies to work jointly with the trusts to reduce their waiting lists. Insourcing companies offering to deliver straightforward elective treatments not only leaves the NHS with complex cases, it also reduces teaching opportunities for doctors as insourcing providers are not obliged to take part in education or training.

Doctors have also found that these companies are increasingly operating on weekdays. This has reportedly interfered with both clinical prioritisation and workforce planning, with doctors moving away from agreed job planned sessions to perform other duties or be on standby.

Outsourcing procedures to ISP hospitals reduces training opportunities

We are concerned that outsourcing NHS-funded elective care will undermine the ability of the NHS to provide adequate training for junior doctors. Four in five doctors (81%) believe that the scope and quality of doctors' training will worsen, given independent sector providers are under no obligation to train staff.

This issue is particularly prevalent in Ophthalmology, where an increasingly significant number of straightforward procedures, such as cataract surgery, are being undertaken in the independent sector. There are long-term concerns that this shift will destabilise NHS-run services, with significant implications for the future workforce pipeline as a result of the loss of NHS training opportunities in these procedures.

However, more immediately, training programmes across the country have reported reduced or disrupted surgical opportunities for trainees, who must complete 350 routine cataract surgeries as a fundamental [requirement](#) of their training and as a means of honing clinical skills to be able to then manage more complicated procedures. The NHS is subsequently left with more complex cases which are less suitable for training purposes. This makes it more difficult for junior doctors to successfully meet training requirements and, crucially, more difficult to develop skilled and experienced consultants.

The uneven distribution of ISP capacity across England could potentially widen existing health inequalities

The Government must recognise that the challenge facing the NHS is not simply one of bringing down elective waiting times as quickly as possible, but as fairly as possible too. Plans to increase ISP utilisation for tackling the elective care backlog, may risk exacerbating health inequalities further. The distribution and concentration of ISPs is critical in this respect. Where it is higher, for example in the [South East](#), this additional capacity could potentially see waiting lists and backlogs in NHS care tackled more rapidly. In contrast, those areas with a smaller ISP presence, particularly in more rural areas, are unlikely to be able to rely on this 'expansion' of capacity. As a result, NHS planning cannot count on the availability of ISP

⁹ The term 'insourcing' has previously been used to describe taking back in-house a service that had been outsourced. However, NHSE/I describe it 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."

¹⁰ Services are performed at prices below NHS tariff largely because these private companies do not have the fixed costs/overheads of their own hospitals. Given NHS budget constraints, this option is increasingly attractive to trusts.

capacity in all areas. Instead, we strongly believe it should focus on funding and supporting existing NHS services.

There are in fact notable regional differences in the use of ISPs for NHS care across England. As the Health Foundation has [reported](#), although independent hospitals are present across the country, there is an uneven distribution of providers willing and able to provide treatment for publicly funded patients.

Moreover, there are further geographical variations in the types of procedure carried out for the NHS. ISPs in the East Midlands and the South East are responsible for [delivering](#) over 40% of NHS-funded hip replacements, compared to just one in 10 (11%) in London. This means that patients waiting for specific treatments in one area may face significantly longer waits than a person waiting for the same treatment in another.

The UK Government's ERP includes a commitment to establish a national network for 'long waiters', which would support some patients to travel to other areas of the country to receive alternative treatment, including from the NHS or ISPs. This could redirect patients facing the longest delays to services with greater capacity, potentially spreading the waiting list burden more equally across the country. Patients who accept this offer will be supported to do so, including assistance with travel and accommodation. However, there is limited information available about how this programme will work in practice, when it will be fully operational, or, critically, how many patients can expect to benefit from it. What we do know from the Secretary of State's 8th March 2022 speech on NHS reform, is that those waiting more than two years will be contacted by the end of this month (March 2022).

Recommendations

1 – NHS capacity must be increased in the medium to long-term

For far too long the Government has sought to manage increasing demand for health services by outsourcing to ISPs – which is proving to be inefficient and poor value for public money – rather than developing a credible plan to increase NHS capacity and ensure patients receive the high quality and timely care they deserve. It is imperative that finite NHS resources, and hard-earned taxpayer money, are not used to bolster ISP finances when capacity and infrastructure within the NHS itself needs extremely urgent support.

The NHS needs more capacity to achieve and maintain the levels of care required to meet population demand. This will also enable services to better manage seasonal and longer-term pressures, such as winter pressures, population growth, people living longer into old age with multiple comorbidities, alongside ensuring we have a more resilient healthcare system when the next epidemic comes along.

A) Grow the NHS workforce and publish a long-term workforce strategy

The Government must promptly develop a workforce strategy that ensures sufficient investment in growing the workforce, and, as a minimum must increase medical school, foundation programme and postgraduate specialty training places and encourage more medical students and junior doctors into training. However, given the time it takes to train a doctor, it is imperative the NHS takes immediate action to retain the existing workforce, including through resolving pay and punitive pension taxation rules that force doctors to reduce their overall working hours or retire early.

National workforce planners must address chronic staffing issues in the NHS, and ensure sufficient, rather than competing, overall medical supply to both the public and independent healthcare sectors. Workforce assessments must therefore acknowledge the fact that many of the doctors working in private hospitals are also NHS doctors. Private medical workforce data must be collected alongside NHS data and should include an accurate FTE breakdown so that it is possible for national workforce planners to ensure sufficient, rather than competing, overall medical supply to both the public and private healthcare sectors.

B) Increase bed capacity

The high levels of NHS bed occupancy, linked with increased pressures in emergency services has often led to the shift of activity to ISPs. Steps must therefore be taken to address bed shortages in the NHS. Instead of acquiring extra beds and capacity from the independent sector, closed NHS acute beds should be reopened with adequate resources in place. This approach would be a far more sensible and efficient way of expanding capacity and would not rely on the transfer or secondment of doctors from NHS hospitals to neighbouring private hospitals to staff these.

2 – A viable exit strategy is needed from Government to reduce the role of ISPs in the delivery of NHS-funded services

We recognise the need to utilise all available capacity in the short term- including in the independent sector – to address the vast backlog of care. However, any arrangements with the independent sector should be time-limited and not a replacement for a credible longer-term plan to increase NHS capacity.

The Government's ERP introduces wide-ranging opportunities for ISP involvement in delivering NHS care and potentially arranging services. Where outsourcing is likely to occur, any associated risks around, for example, patient safety and reduced medical training in ISP settings must be appropriately mitigated. The independent sector must only be used as a last resort and only as a short-term solution when rapid expansion of NHS capacity is necessary to safeguard patient care.

A) Where outsourcing is likely to occur, ISPs must contribute towards the education and training of the current and future NHS workforce

BMA members (81%)¹¹ continue to express concern over the lack of training opportunities afforded in the independent sector. Historically, ISPs have made use of staff who have been trained in the NHS using public money but make a minimal contribution to training future doctors. However, during the pandemic steps were taken to improve training in ISP settings given the elective outsourcing arrangements after the fact the NHS largely postponed elective surgery to focus on COVID care.

It is crucial that, during both this recovery period and in the NHS' future, the training and education of junior doctors is prioritised, and trainees are not just used for service provision, regardless of the setting in which they work. There is a significant risk that unless current trainees can rapidly catch up on their elective training opportunities and experience, that many of them may have to prolong their training and delay their CCT (certification of completion of training). If this happens it will rapidly restrict the supply of new consultants and further exacerbate workforce issues and jeopardise the elective recovery plans.

To ensure that the next generation of doctors are equipped with appropriate levels of training, the NHS Standard Contract should be amended to require ISPs to contribute towards the education and training of the NHS workforce – both financially and by virtue of making available suitable opportunities. At a minimum, providing training for junior doctors should be a precondition of ISPs accepting NHS work and must be an explicit part of any outsourcing contracts.

B) Patient safety standards must be safeguarded in ISP settings

Adequate risk assessments must be built into any new agreements with ISP hospitals to ensure robust patient safety. Within this, it must be ensured that pre-operative checks are aligned for NHS and private hospitals.

Patients on waiting lists must be provided with information about how care is organised in the independent sector compared to the NHS. It must be made clear that most independent hospitals are not equipped with critical care facilities and therefore may not be prepared to deal with health complications when they arise. Where there are no critical care facilities in ISPs, there must be structured arrangements in place to ensure patients can be safely and swiftly transferred to the right environment should they need higher acuity care.

C) Outsourcing arrangements must not widen health inequalities

People in the most deprived areas are far more [likely](#) to experience delays in receiving hospital treatment compared to the least deprived. To avoid widening health inequalities, more information must be made available regarding the transfer of 'long waiters' to areas with increased hospital capacity.

D) ISP contracts and public spending on ISPs must be transparent

Where NHS contracts are provided and run by the independent sector, it is crucial that a clear and transparent governance system is in place, including contracting and financial arrangements. The costs and performance of the approved framework suppliers must be monitored and scrutinised to ensure that taxpayer money is not being wasted on ISPs who are not delivering on their contracts.

The BMA has repeatedly called for greater clarity and consistency in the collection of independent sector spending data to enable more accurate analysis of the extent of outsourcing within the NHS in England. The present lack of publicly available information on spending makes it difficult to quantify the amount of public money

flowing to ISPs. While information on the proportion of public health expenditure allocated to ISPs is contained within the DHSC annual reports and accounts, this information is difficult to understand and requires a degree of interpretation.

3 – The Health and Care Bill must be amended to safeguard the NHS from further outsourcing

Government and NHS leaders must take action to ensure that NHS reforms protect the long-term future of the NHS, by enshrining the NHS as the default option for NHS contracts, precluding ISPs from sitting on ICBs or their key committees, and by making the Health Secretary responsible for delivering adequate staffing levels.

A) The default provider for NHS contracts must be the NHS

To protect the NHS from fragmentation and destabilisation due to the outsourcing of NHS contracts to ISPs, it is essential that the Health and Care Bill establishes the NHS as the default option for services.

Irrespective of the final content of the Health and Care Bill, we would expect ICBs to prioritise the NHS in their commissioning decisions, to support integration, prevent fragmentation, and ensure long-term investment in NHS capacity.

B) The Government must rule out independent sector companies wielding influence over commissioning decisions

The BMA is clear that ICSs should be run by NHS and publicly accountable bodies. Corporate providers should not be eligible to sit on key ICS boards or committees, including ICBs (Integrated Care Boards), ICPs (Integrated Care Partnerships), or Elective Recovery Boards, or be directly involved in commissioning decisions.

As it stands, the Health and Care Bill leaves open the possibility for corporate healthcare providers to gain seats on ICBs which would allow them to influence ICS strategies and risk conflicts of interest in commissioning decisions. The BMA has been clear that ISPs should be precluded from sitting on these, to avoid undue influence over decisions these providers benefit from financially and conflicts of interest over commissioning decisions. This position would extend to the inclusion of ISPs sitting on ICS Elective Care Boards, which would potentially allow them to influence local decisions and the commissioning of routine, profitable work.

C) The Government must be responsible for ensuring adequate staffing levels in the NHS

The Government must be accountable for ensuring health and care systems have the workforce required to meet the needs of the population, now and in the future. To deliver accountability for safe staffing, the Bill must include a responsibility for the Secretary of State to produce ongoing, accurate and transparent workforce assessments to directly inform service recruitment needs as well as who has the responsibility for delivering these. The Government must not overturn the House of Lords' amendment on workforce planning to the Health and Care Bill, which provides a vital mechanism for ensuring we have a shared collective, national picture of the health and care staff we need to keep pace with projected patient demand, both now and in the future.

Appendix 1:

Healthcare budget for non-NHS providers	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Independent Sector Providers	-	6,467	8,067	8,818	9,007	8,765	9,180	9,692	12,170
Voluntary Sector/Not for profit	-	510	526	545	757	1,564	1,619	1,705	1,866
Local Authorities	-	2,473	1,774	2,869	2,909	2,737	2,889	2,984	4,312
Total Spend on all non-NHS bodies	8,970	9,450	10,367	12,232	12,673	13,066	13,749	14,430	18,379
NHS Trust spend on ISPs	221	645	779	945	1,068	1,106	1,328	1,486	1,689
Total DHSC RDEL	105,475	106,495	110,554	114,730	117,031	120,650	125,278	134,183	180,199
Spend on all non-NHS bodies as a % of total RDEL	8.71%	9.48%	10.08%	11.49%	11.74%	11.75%	12.03%	11.86%	11.14%
Spend with private sector as a % of total RDEL	-	6.7%	8.0%	8.5%	8.6%	8.2%	8.4%	8.3%	7.7%

Source: DHSC annual reports and accounts in cash terms

Healthcare budget for non-NHS providers	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Independent Sector Providers	-	7,613	9,367	10,158	10,126	9,681	9,909	10,233	12,088
Voluntary Sector/Not for profit	-	600	611	628	851	1,727	1,747	1,800	1,853
Local Authorities	-	2,911	2,059	3,304	3,270	3,023	3,119	3,151	4,283
Total Spend on all non-NHS bodies	10,752	11,125	12,038	14,090	14,247	14,431	14,842	15,236	18,255
NHS Trust spend on ISPs	221	760	905	1,088	1,201	1,222	1,434	1,569	1,678
Total DHSC RDEL	126,430	125,368	128,372	132,160	131,564	133,252	135,232	141,675	178,987
Spend on all non-NHS bodies as a % of total RDEL	8.68%	9.48%	10.08%	11.48%	11.74%	11.75%	12.04%	11.86%	11.14%
Spend with private sector as a % of total RDEL	0.2%	6.7%	8.0%	8.5%	8.6%	8.2%	8.4%	8.3%	7.7%

BMA analysis of DHSC annual accounts and spend adjusted for inflation

