The New Health and Social Care Economy

Sefton MBC, Liverpool and Greater Manchester City Regions and North West regional economy

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The **European Services Strategy Unit** is committed to social justice, through the provision of good quality public services by democratically accountable public bodies, implementing best practice management, employment, equal opportunity and sustainable development policies. The Unit continues the work of the Centre for Public Services, which began in 1973.

Research has included health and social care economy studies for the North West and East of England regions; two social and economic audits of health care in North Ireland; critical analysis of the case against the sale of residential care homes and/or outsourcing adult social care in over 15 local authorities, many in the North West; a successful alternative to the outsourcing and offshoring of prescription processing by NHS Business Services; the case for a Public Duty for Age Equality; the gender impact of outsourcing; and a analysis of the original Cashing in on Care proposals in 1984.

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Abbreviations

A&E	Accident and Emergency
AQP	Any Qualified provider
CCG	Clinical Commissioning Group
CHP	Community Health Partnerships
CSU	Commissioning Support Unit
CETA	Comprehensive Economic and Trade Agreement
CIC	Community Interest Company
CIPFA	Chartered Institute for Public Finance & Accountancy
CQC	Care Quality Commission
DCLG	Department for Communities and Local Government
DH	Department of Health
EU	European Union
FM	Facilities Management
FTE	Full Time Equivalent
GP	General Practitioner
GDP	Gross Domestic Product
GVA	Gross Value Added
HSCIC	Health & Social Care Information Centre
ISTC	Independent Sector Treatment Centre
LATC	Local Authority Trading Company
LGA	Local Government Association
LEP	Local Enterprise Partnership
LIFT	Local Improvement Finance Trust
MBC	Metropolitan Borough Council
NHS	National Health Service
ONS	Office for National Statistics
PFI	Private Finance Initiative
PPP	Public Private Partnership
TISA	Trade in Services Agreement
TTIP	Transatlantic Trade and Investment Partnership
TUC	Trade Union Congress
UK	United Kingdom
WTC	Working Tax Credit

Executive Summary

New approach to the health and social care economy

A new ten-part model of the health and social care economy encompasses public health, wellbeing and tackling inequalities; the health and social care infrastructure; economic value, supply industries and services and the quality of jobs; improvement and reform, research and innovation, democratic governance, sustainable development and medical/health education and training.

A holistic approach is critical to maximise the local, regional and national benefits of health and social care system. It reinforces the need to fund the whole system, maximise the use of resources and to identify ways to improve the productivity and effectiveness of the health and social care system. The model helps to identify interdependencies in the healthcare system and to challenge how different parts are valued.

The new model is essential to understand the full impact and costs and consequences of reform policies that increase competition, marketisation and privatisation. An assessment of a sample of current local, regional and national NHS reports demonstrate a very limited understanding of the health and social care economy.

Importance in North West regional economy

The North West had the third largest total regional Gross Value Added outside of London and the South East in 2013. The health and social care economy accounted for 8.6% of the region's wealth in 2012. North West health expenditure was £15.1bn, the third highest in England after London and the South East.

Deep cuts in public expenditure

60% of the government's cuts in public services have yet to be implemented, so talk of 'after austerity' is illusory. Austerity policies have increased poverty, homelessness and ill-health, not least for disabled people. The 2015-16 Local Government Financial Settlement imposed an average cut of 1.8% on local authority revenue spending, but much larger reductions were imposed in Knowsley, Liverpool and Manchester of 6.0%, 5.9% and 5.1% respectively.

Chronic underfunding of social care in England has led to a 40% reduction in weeks-of-care for day care and home care by nearly 20% between 2008-2009 and 2013-2014. This could severely limit implementation of the Care Act 2014.

Major employer in the local and regional economy

The NHS, public bodies, private and voluntary sector organisations in the North West directly employ 551,802 people. The same organisations purchase goods and services that support a further 129,433 jobs in the North West. The household expenditure of the directly employed workforce plus those employed in providing goods and services in the regional economy support a further 159,403 jobs. Thus health and social care services in the North West generates 840,638 jobs (or 701,031 full time equivalents).

Four out of five of the North West NHS non-medical staff and the social care workforce are women in contrast to 43% of the medical staff and a similar percentage of dentists. Just over half of GPs and opticians are women. 26% of the NHS medical staff in the North West is Asian or Asian British and 54% white, which contrasts with the non-medical staff where only 3% are Asian or Asian British. Both the non-medical and adult social care workforce are predominately white.

In addition, there were 781,972 people providing unpaid care in the North West in 2011, of whom 113,003 carers provided between 20-49 hours per week and 199,476 carers provided over 50 hours per week.

Quality of care linked to quality of employment

There is conclusive evidence of a strong connection between the wellbeing of healthcare staff and the quality of care patients receive and their health outcomes. The health and social care economy approach encourages a more holistic perspective of patient/community needs, organisational and political boundaries to seek solutions to peoples needs, accelerate collaboration, and ultimately service coordination and integration between health and social care organisations.

Outsourcing continues

North West NHS Trusts and CCGs outsourced £41m of contracts to private and voluntary sector organisations between April 2013 and November 2014. In addition, NHS Trusts in the region outsourced £268.6m of facilities management services in 2013-2014. Evidence from several other regions reveals a growing trend of outsourcing core medical services. Local authorities now employ only 13.2% of social care staff in the region. A contract culture, financial crises, marketisation and privatisation have increased significantly since the original 2003 Health and Social Care in the North West economy analysis.

Increased role of private finance

The capital value of Private Finance Initiative hospital projects in the North West more than doubled from £765m in 2003 to £1,909m by 2014. The remaining unitary payments for PFI projects total £10,686.9m. The cost of services accounts for an average 40% of unitary payments, which would be incurred by the trusts irrespective of PFI projects, leaving a debt of about £6.4bn.

Twenty-three equity transactions took place in the North West PFI healthcare projects between 2005-2014, including the eight major PFI hospital projects. A majority involved the transfer of equity ownership to offshore infrastructure funds in Luxembourg, Jersey and Guernsey.

Social impact bonds are similar to PFI projects and are being promoted as a new way of financing health and social care, and they only serve to strengthen the privatisation of policy making, innovation, finance, contract management, service provision and the evaluation of performance.

Public cost of marketisation and privatisation

Significant public costs are incurred by public bodies in transferring services, private finance projects, wasted bids, contract terminations, public subsidies, reorganisation and consultancy costs. The national annual costs total nearly £7.5bn or £1.1bn per annum in the North West.

Corporate role in the health and social care economy

Increased outsourcing, private finance and use of the private hospitals by the NHS, is bolstering the private sector's role in the region. Approval of the Transatlantic Trade and Investment Partnership will lead to further deregulation and privatisation.

Impact on jobs and wages

Nearly 100,000 of the North West social care workforce could be earning less than the Living Wage. Zero hour contracts, 15-minute care visits, non-payment of travel costs, and high turnover rates are common in social care.

The North West share of the annual £1.2bn Working Tax Credit expenditure in the health and social care sector is approximately £147m per annum – in part a subsidy to private contactors low pay policies.

New care models and integration are unlikely to achieve genuine and effective care in the community, with the NHS continuing to absorb the high cost of this failure, until social care is equally valued and funding is available to end the exploitative, if not Victorian, employment policies.

Continuing health and economic inequality

A snapshot of health inequalities in the region is followed by an account of the Coalition governments attempt to reduce or eliminate adjustment for health inequalities in allocating resources. Income inequality is increasing in the UK and other industrialised countries. The gap between productivity and pay has markedly increased.

Regional industries and research

The North West is a major centre for biomedical research and has over 200 companies in biotechnology, pharmaceutical and healthcare industries. It is the largest cluster of advanced flexible materials manufacturers in Europe. The region has two Academic Health Science Networks funded to speed up innovation and collaboration.

Demographic change

The North West population is forecast to increase 3.6% between 2012-2022, half the rate for England. The region has eight of the ten local authorities with the lowest projected growth in England in the same period. The North West population aged 65 and over is forecast to increase by 56% in the 2010-2035 period

compared to a 4.8% increase in the 20-64 age group. Taking account of productivity improvements, between 77,000 and 63,000 new jobs will be required in health and social care services in the North West by 2035.

Reconfiguring health and social care

Continued marketisation and privatisation of the health and social care economy, in particular the commercialisation of NHS trusts and CCGs, is unsustainable. Assertions that the NHS will remain 'free at the point of use' are meaningless if health and social care is largely provided by private companies. This will fundamentally change the scope, range and quality of services and the principles and values on which health and social care is provided.

Integration initiatives can lead to better services, but there is very little evidence that it can achieve cost savings. Local and practical initiatives are likely to be more effective than further system-wide organisation.

Telehealth and telecare and new digital applications will have a significant impact on the delivery of health and social care. However, the geographic coverage, security, reliability, affordability and sustainability of high-speed broadband remain a key issue. Big data systems will be required, which the NHS and social care system will operate, although it is very likely they will not own or operate them directly, but through managed services contracts.

Planning and growth

Major infrastructure projects in the North West include the planned HS2 from Birmingham via two routes to Manchester and Leeds, the longer-term plan for the HS3 from Liverpool via Manchester and Leeds to Hull and several rail electrification projects. Up to 25,000 new homes are planned in the North West.

The growth areas provide an opportunity to provide state of the art facilities and public services through public investment. However, continued outsourcing of NHS and local government services will mean that private firms will be in a powerful position to win contracts in the new growth areas. This could have a significant knock-on effect on health and social care services in other parts of the North West as the private sector seeks economies of scale. It could raise a conflict of priorities between the allocation of resources in the new growth zones or investment to tackle inequalities in inner city areas.

Devolution, democratic accountability and participation

From April 2016 the £6bn NHS budget for Greater Manchester will be devolved to the Greater Manchester City Region (Combined Authority). This decision has significant potential benefits and negative consequences in equal measure until further details are revealed. Significant questions remain about democratic governance and participation.

NHS England often makes reference to staff wellbeing, but this does not include participation, involvement or engagement (NHS England 2014a and 2014c). It must be developed across the health and social economy. As ever, if the ideas, experience and innovation of staff are not harnessed in the reconfiguration of health and social services, it would be a lost opportunity and limit the effectiveness and benefits of reconfiguration.

Recommendations

The recommendations are divided into two parts. Firstly, health and social reconfiguration should urgently address the following priorities:

1. Secure long-term funding for the NHS with an immediate significant increase in local authority social care expenditure, together with a planned return to grant funding of community and voluntary organisations;
2. Begin an immediate roll-back of marketisation and privatisation by cancelling planned procurements; rigorous monitoring and review of outsourced contracts; the replacement of outsourcing with in-house service innovation and improvement plans prepared with staff, patient/user involvement,together with three-yearly service reviews;
3. Stop the transfer of NHS and local government services to social enterprises and trading companies, but increase their role in supply industries and research;
4. Public investment to replace Private Finance Initiative, social impact bonds and other private finance projects for health and social care infrastructure and services.
5. Immediately improve the terms and conditions for low paid workers, particularly in social care, with a living wage and an end to zero-hour contracts;

6. Achieve real and sustainable integration of health and social care services with collaboration and joint working between NHS Trusts, CCGs, local authorities and other public bodies;
7. Maximise regional benefits from closer cooperation between NHS trusts and local authority social care organisations, research institutes, innovation funds and the manufacturing and supply sectors;
8. Draw up local, city region and North West regional plans to develop the health and social care economy, to include housing and health adaption, emission reduction and renewable energy projects;
9. Prioritise local, city region and regional funding and action strategies to tackle health and economic inequalities;
10. Increase democratic accountability, scrutiny and transparency of NHS Trusts, health and social care organisations;
11. Launch a programme to involve staff and patient/user representatives in innovation and improvement, service integration and joint working initiatives;
12. Draw up a staff and management retraining programme to reinforce NHS principles and values, and public service management practice.

More detailed recommendations are grouped under reconfiguring health and social care; improvement and innovation; public ownership and investment; improving wages and benefits; assessing costs, benefits and impacts, tackling inequalities and democratising health and social care.

Reconfiguring health and social care

- The North West definition of the health and social care economy should be incorporated into policy-making, project proposals and business cases.
- Increase the awareness of the scope and importance of the health and social care economy and how its different dimensions can be incorporated into planning and decision-making.
- Local authorities and their care organisations should be proactive in responding to local hospital crises by offering to adjust service provision, such as reablement, to unlock blocked beds and to propose longer-term service redesign.

Improvement and innovation

- CCGs, NHS Trusts and local authorities should focus on in-house service delivery options, including a proactive role in developing NHS consortia or partnerships with procurement as a last resort.
- NHS organisations and local authorities should ensure that patient and community organisations are fully involved in health and social care planning and service improvement.
- Future health and social care infrastructure investment should be funded by direct public investment.
- CCGs, NHS Trusts and local authorities should strengthen their ability to monitor, review and scrutinise health and social care services.
- Health and social care organisations should operate with flatter management structures, devolve more responsibility to frontline staff.
- The NHS and local authorities should increase collaboration with research bodies in the region.
- Employer responsibilities linked to personal budget direct payments should be strenuously discouraged.

Public ownership and investment

- The government must substantially increase the resources for local government and specifically for care.
- The buy-out of PFI projects should only be considered if the government establishes a new Treasury debt-buy-out scheme.
- The outsourcing of NHS and local authority services to private and non-profit contractors should be drastically reduced and sanctioned only in circumstances of exceptional need.
- The purchaser/provider spilt should ultimately be abolished and replaced by policies that prioritise in-house provision supported by Service Reviews and three-year Service Innovation and Improvement Plans.
- The function of local CCGs and combined sub-regional CCGs and CSUs should be changed to develop a more integrated health and social care system by advising and supporting NHS Trusts and local authorities.
- CSUs must be retained in the public sector, otherwise they are likely to become a vehicle to drive further marketisation and privatisation in the NHS.
- Engage in the consultation of the NHS Reinstatement Bill that will reinstate the

government's legal duty to provide the NHS in England.
- Oppose the Transatlantic Trade and Investment Partnership (TTIP) and the Trade in Services Agreement (TISA) free trade agreement that are almost certain to increase the marketisation and privatisation of public services.

Improving wages and benefits

- The Living Wage should be paid to directly employed staff in health and social care public bodies and a requirement in outsourcing contracts.
- Increased regulation and enforcement of minimum wage legislation.
- Health and social care public bodies that transfer staff under the TUPE regulations should ensure that contractors meet their regulatory obligations.
- NHS organisations and local authorities should develop strategies for improving the health and wellbeing of their workforce, drawn up with staff and trade union representatives, and regularly monitored and reviewed.
- Contractor pay rates, pensions, and other terms and conditions, to be taken into account in the quality component in the evaluation of bids.
- The use of zero hour contracts should be abolished and 15-minute care time slots made permissible only in very limited circumstances.
- Statutory guidance should require NHS organisations and local authorities to include payment of travel time as a contract condition for home care providers.
- Care Quality Commission inspections of health and social care organisations should be extended to assess staff health and well-being standards and targets, which should include terms and conditions of employment.
- Public, private, non-profit and voluntary sector care providers should immediately implement UNISON's ethical care charter and regularly monitor and review progress.
- NHS employers, local authorities and Skills for Care should develop a career development framework for health and social care staff.

Assessing costs, benefits and impacts

It is vitally important that decisions on the provision of health and social care are preceded by rigorous cost benefit analysis and economic, social, environmental, equality and health impact assessment.

- Ensure a full public sector wide cost analysis is undertaken prior to any outsourcing and privatisation decisions.
- Economic, social and environmental impact assessments (including sustainability appraisals) should be carried out for the procurement of services, development and infrastructure projects.
- Equality impact assessments should include the direct impact on service users and staff and the wider community and local economy.
- NHS Trusts and other health and social care organisations should strive to maximise the local or regional sourcing of goods and services.

Tackling inequalities

- It is strongly recommended that a social justice approach should be adopted in further analysis of the health and social care economy in the North West.
- The provision of adequate and affordable social and key worker housing in close proximity to major health and social care facilities is essential.

Democratising health and social care

- The formation of new NHS and local authority owned/controlled health and social care organisations, joint ventures and partnerships in the region must be democratically accountable and transparent.
- NHS organisations and local authorities should take immediate steps to involve staff and trade unions in the reconfiguration process.
- NHS Trusts should be represented on Health and Wellbeing Boards, which should a duty to increase the democratisation and participation in the health and social care economy.

Transparency

- Freedom of Information requirements must be extended as a matter of urgency to private, non-profit and voluntary sector companies and organisations providing public services.
- Private health sector data collection must be re-instated together with regularly updated information on the private health and social care sector.
- CCGs should be required to fully cost and disclose every options appraisal, procurement and market making activity.

Part 1 New approach to the health and social care economy

Advancing the health and primary care economy

This analysis of the health and social care economy is based on NHS Trusts provision of healthcare, the primary care network of general practices and health centres and the provision of social care (residential and home care). It includes private hospitals, clinics and care homes; medical schools; biomedical research; medical education and training; those employed in the construction of the health and social care infrastructure; and those engaged in the supply of goods and services.

The health and social care economy has ten inter-related parts (Figure 1):

Public health, wellbeing and tackling inequalities: Health and social care services enable people to be more economically active and productive, to access education and training and to ensure the wellbeing of children and the elderly. Public health and health promotion – fitness, healthy eating, reducing obesity – has both economic and health benefits. Early intervention, support and rehabilitation are vital for those who have physical, learning or mental illness and those recovering after medical care. The economy imposes stresses, strains and pressures on healthy living, which impose additional demands on health and social care services.

Reducing economic and health inequalities should be a core objective of the health and social care economy. It has a responsibility to the communities it serves and to the staff it employs. Continuing inequalities are a fundamental barrier to health and social care integration.

Economic output and value: Health and social care provision makes a significant contribution to the value of output in the economy through service delivery, support services, construction, research and supply industries. Growth in the health and social care sector has offset the decline in Gross Added Value in manufacturing and other sectors. Health and local authorities are often major employers in the local economy (Table 1). Health and social care staff plus those employed in the supply of goods and services to health and social organisations spend their household income in the local and regional economy they support additional jobs in local shops and services. This is direct, indirect and induced employment.

Health and social care infrastructure: The health and social care system requires an infrastructure from hospitals, clinics, health centres, surgeries, care homes to extra care housing together with support functions such as IT, finance and HR. Investment of the built environment ranging from the planning, design, construction and maintenance of facilities has economic benefits and provides a significant range of jobs and career opportunities.

The health and social care economy operates most effectively at city, city region or regional level to take account of the geographic spread of specialist provision to meet most community needs, collaborative and joint working and the location of research centres and supply industries. The organisational and physical infrastructure is only one dimension and cannot be taken in isolation of the other core parts of the health and social care economy.

Supply industries and services: The production and supply of medical and non-medical goods and services is vitally important for hospitals, health centres, residential care homes and social care services and makes a significant contribution to employment and the regional economy.

Research and innovation: Investment in research and innovation has a vital role in improving the quality and effectiveness of healthcare, productivity and cost effectiveness. Life sciences research, including biomedical and advanced flexible materials and textiles, involving the NHS, universities and industry, has the potential to create a virtuous circle of advanced research centres, industrial inward investment, increased local and regional economic development and employment, frontline NHS innovation and improvement, and increased export potential for UK-based companies.

Quality of jobs: Health and social care systems require a wide range of trained, skilled and experienced staff. Hence the pay, pensions and other terms and conditions of employment are vitally important to

recruit and retain staff and to ensure joint working and collaboration between services. The NHS and local government influence standards for other employers in the local and regional economy.

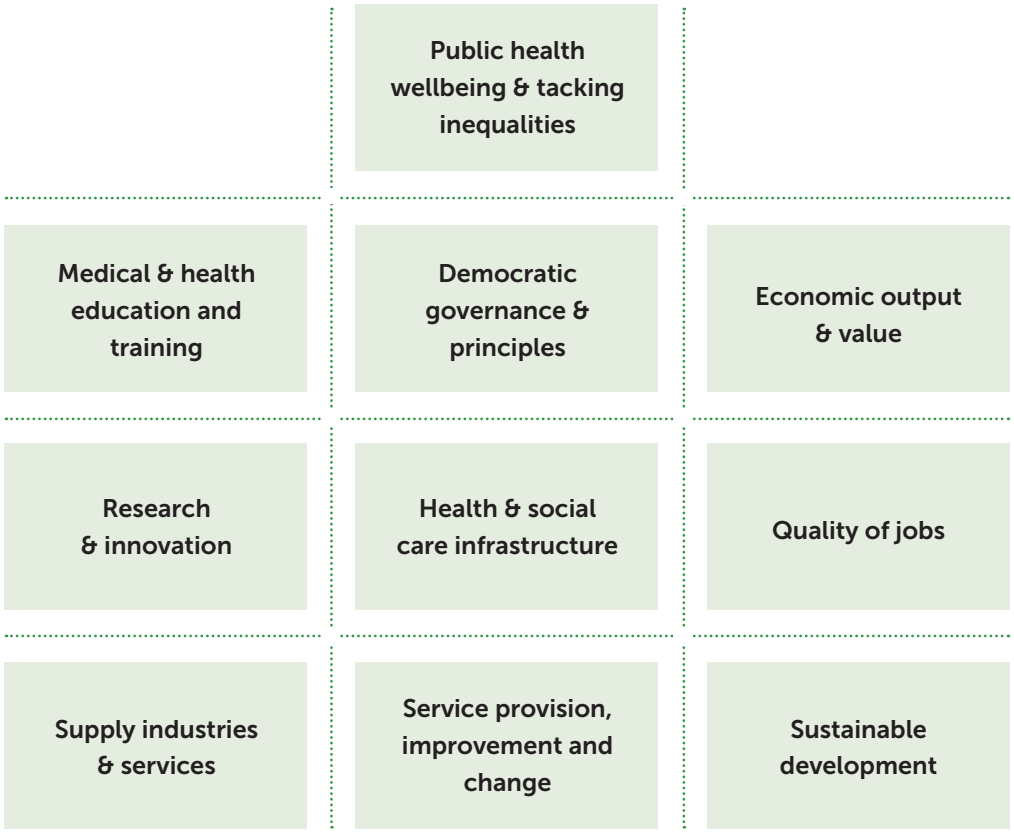
Service provision, improvement and change: Direct public provision should be the default model for health and social care services with a rigorous evaluation and impact assessment if other options considered. The methods used to reform health and social care services have a knock-on effect on the reform process in other public services, and vice versa. Collaboration or market competition and their respective principles and values, determine the public, private and voluntary sector role in the health and social care economy and the ownership of assets. The method of reform affects the stability of the health and social care economy and the extent to which economic benefits are retained in local/regional economies.

Democratic governance and principles: The health and social care economy must be accountable, participative and transparent to maximise the local and regional economic, social and environmental benefits underpinned by public sector principles. Rigorous monitoring, review and scrutiny, together with patient/service user, community and staff/trade union involvement in the planning and design of services are vital to sustain accountability, ensure services are based on community needs and to improve the quality of service.

Medical/health education and training: The education and training of doctors, nurses and health specialists has a vital role in the health and social care economy. It includes workforce development and ensuring the right number, skills and behaviours; responsive to research and innovation; NHS principles and values and professional and technical retaining.

Sustainable development: Progress towards a clean energy economy is necessary to protect and improve health now and for future generations. The health and social care economy is a large consumer of energy and water, a producer of clinical and domestic waste and transport-related carbon emissions. Hospitals have a significant environmental impact. It is, therefore, vital to reduce carbon emissions, minimise waste and pollution and address the health impacts of climate change. *"Building preparedness and resilience now to the predicted health impacts of climate change will save costs in the short and long term, protect lives and deliver health outcomes"* (Public Health England and NHS England, 2014).

Figure 1: **The health and social care economy**



The health and social care economy model provides a framework to take account of the inter-relationships between the different functions of the health and social care system. It ranges from the funding and provision of hospital and social care to the role of research, innovation, training and supply chain industries in service redesign. Change in one part of the system usually has a positive or negative knock-on effect in other parts. For example, the procurement of hospital medical and related services inevitably impacts on other services and the financial stability of NHS Trusts. Assessing impacts and, if necessary, taking mitigating action should be an integral part of the planning and design process. Although options appraisals, value for money and impact assessments should identify potential costs and benefits, they are often have limited effect in constraining a commercialisation strategy. Neoliberal public management has led to lurches in national public policy-making ranging from compulsory tendering, best value, targets and performance management and more recently commissioning and outcomes. The resultant 'mixed economy' of public, private and voluntary management practices, operational and financial objectives lead to fundamental conflicts of interest. A framework of public sector principles and values should determine practice and replace simplistic slogans about maintaining 'the NHS free at the point of use'.

Context and objectives

The original Health and Social Care Economy in the North West report was published by the North West Regional Assembly in 2003. This new study develops and expands the analysis, uses the latest statistics and assesses new challenges and opportunities in the health and social care economy in 2015. It has six key objectives:

1. To quantify the scale and role of the health and social care economy in Sefton, the Liverpool and Greater Manchester city regions and the North West region respectively.
2. To assess the impact of the recession and austerity policies to date and the implications of further cuts in public spending.
3. To identify the health and social care linkages to manufacturing, research, training and other services in the local, city region and regional economies.
4. To identify ways in which the health and social care economy can maximise opportunities to increase social justice, sustainable development and reduce health inequalities.
5. To assess the employment impact of the health and social care sector and the policies needed to improve the quality of employment.
6. To identify how the local, city region and regional economies can maximise economic and social benefits in meeting future health and social care needs and reducing health inequalities.

The health and social care economy is examined at three levels, the Sefton local economy, the two city regions of Liverpool and Greater Manchester, and local authorities in Cumbria and Lancashire and the North West region.

Limited vision of the health and social care economy

The term 'health and social care economy' is more widely used than a decade ago, but has different meanings. To highlight these differences a representative sample of ten policy and strategic plan documents (ranging from nation, regional and local, including NHS England, Liverpool City Region, Greater Manchester City Region, local Clinical Commissioning Groups) were selected to determine their approach to the health and social care economy. The documents examined were:

- South Sefton and Southport and Formby CCGs joint 5 Year Strategic Plan, 2014
- Sefton Economic Strategy 2012-22
- Liverpool City Region Growth Plan and Strategic Economic Plan, 2014.
- A Plan for Growth and Reform in Greater Manchester, 2014
- NHS England: Five Year Forward View, 2014.
- Commission on Hospital Care for Frail Older People, 2014
- Reforming the NHS from within, Kings Fund, 2014
- Dalton Review, 2014
- Kingsmill Review, 2014
- Monitor, NHS England and Trust Development Authority, Making local health economies work better for patients, 2014

Each report was searched for references to the 'health economy', 'health and social care economy' and 'health and wellbeing economy'. Each reference was assessed to determine the context in which it had been used, the implied definition, the level of detail provided and the extent to which economic and/or employment consequences of health and social care policies were taken into account.

Four of the ten documents did not refer to any of the three terms - Sefton Economic Strategy 2012-22; Liverpool City Region Growth Plan and Strategic Economic Plan, 2014; Reforming the NHS from within, Kings Fund, 2014; and the Kingsmill Review, 2014. The Commission on Hospital Care for Frail Older People, 2014 made one reference at the beginning of the report *"There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies"* (page 1).

NHS England's Five Year Forward Plan was limited to statements in referring to *"...assessing the characteristics of each health economy"* and allowing *"...joint intervention in health economies"* with reference to implementing the new care models set out in the report (page 25).

The importance of quicker transformational and transactional change with systems leaders needing *"...to collectively own the transformation required across their local health economies"* is one of the key recommendations of the Dalton Review (page 7). It also called for simplifying the planning and 'gaining consensus stages' of the process across the health economy. The review found where transformation experienced 'entrenched challenges' and current resources were inadequate the Department of Health should consider *"...whether central investment can be justified based on the future returns for the health economy"* (page 33).

South Sefton and Southport and Formby CCGs joint 5 Year Strategic Plan, 2014 (pages 15 and 16) referred to the complexity of the local health economy, the need to integrate plans between partner CCG in the Merseyside health economy and to sustain strong performance on a sustainable basis *"...to further innovate and transform services to meet the health need of the population going forward."* The plan identifies six system characteristics for a sustainable health economy (page 26).

The Plan for Growth and Reform in Greater Manchester, 2014 stresses that investment must be focused on the contribution of new care models, otherwise significant financial pressures will remain across the health and social care economy (page 16). The plan estimates that if current arrangements continue, the Greater Manchester health and social care economy will face a £1.1bn fiscal challenge in the five year period to 2017-2018 and sets out proposals for health and social care integration.

The Monitor, NHS England and Trust Development Authority, Making local health economies work better for patients (2014) is a comprehensive report on local health economies (LHEs). However, it is based on a narrow definition – *"A health economy is a designated geographic area containing multiple healthcare organisations that between them have numerous financial and clinical interactions"* (page 4).

Monitor examines eleven local health economies including Cumbria and the Eastern Cheshire/Southern Sector in the North West, supported by consultants who *"...worked with local commissioners and providers across each health economy to explore the options for the future shape of healthcare services within the area and to reach consensus on a clear way forward"* (Monitor et al, 2014). The designated areas were selected to develop five-year strategic plans and detailed two-year operational plans in place of the annual plans previously produced. The Intensive Planning Support Programme (IPSP) was intended to deliver additional support designed *"...to identify solutions that fixed the problems with the health economy and helped ensure commissioner and provider plans were aligned and deliverable"* (ibid). The emphasis on health care is demonstrated by the lessons from the IPSP programme that show successful local health economies will be those that:

- understand the challenges in securing clinical and financial sustainability
- articulate a clear case for change, based on the benefits for patients
- engage extensively with patients, the public, stakeholders and staff during both the design and delivery of change programmes
- enable clinicians to take a leading role in the design and delivery of change programmes
- prepare robust implementation plans and provide the appropriate resources for the delivery of change
- ensure the right capability and capacity are in place for managing complex changes
- promote the right leadership behaviours to drive change forward, putting the interests of patients and carers above the interests of individuals and organisations.

Overall, the level of understanding of the health and social care economy was very limited.

Four of the reports did not even refer to the health economy. Two others made very brief reference. The Dalton Review's limited reference leaves only four that discussed the health economy in a more substantive way.

The Monitor report was the most detailed, but was based on a very narrow definition of the health and social care economy and limited to health organisations in a geographic area.

Importance of the NHS, local authorities and universities in local economies

NHS Trusts, local authorities and universities are major employers in the local and the North West regional economy. Although only between 15%-20% of local authority staff are engaged in social care and public health and medical/health education staff account for only part of total university staffing, the data highlights the economic importance of these organisations (Table 1).

The figures underestimate the size of the health and social care economy because they do not take account of Clinical Commissioning Group and Commissioning Support Group employment, research and those employed in the supply of goods and services in the health and social care economy.

Table 1: **NHS Trust, Local authority and university employment in the North West**

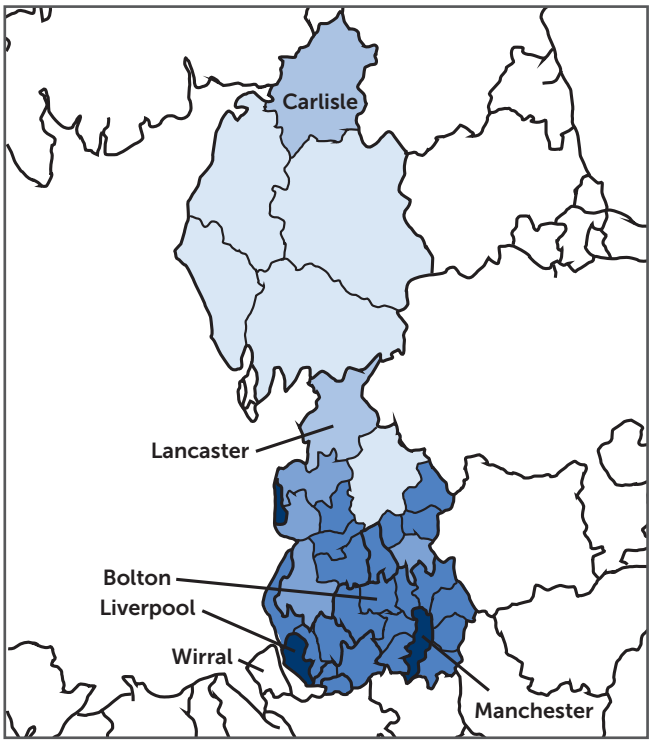
Local authority	NHS Trusts workforce (FTE)	Local authority Headcount Q3 2014	University Employment (FTE)
Sefton	2,913	10,097	-
Liverpool	18,301	14,266	7,952
St Helens (and Knowsley)	3,901	6,905	-
Knowsley		5,957	-
Wirral	4,928	9,835	-
Bolton	4,931	10,066	500
Manchester	21,694	16,367	13,835
Oldham (and Rochdale and Bury)	8,541	7,026	-
Rochdale		8,931	-
Bury		7,213	-
Salford	6,224	8,679	1,981
Stockport	5,063	9,231	-
Tameside	2,457	6,779	-
Trafford	1,450	5,430	-
Wigan	7,167	9,755	-
Cumbria	3,359	7,122	986
Blackpool	5,816	5,704	1,051
Preston	6,728	1,208	2,426
Lancashire	4,435	37,949	
Blackburn with Darwen	7,223	6,512	-
Warrington	3,599	6,904	-
Cheshire East	6,165	8,373	-
Cheshire West & Chester	6,324	10,141	1,480

Source: NHS Trust Annual Reports 2013-2014, ONS Public Sector Employment Survey, 2014 and University Annual Reports/Financial Statements 2013 and 2014

Methodology

The methodology is summarised in Appendix 1. There are three categories of core employment data - *direct employment* by health and social care employers in the public, private, social enterprise and voluntary/ community sectors providing services to the NHS, local authorities and General Practices; *indirect employment* in industries and employers supplying these organisations (the supply chain) in the region, in other parts of England and the UK and abroad; *induced employment* in the local economy generated as employees spend their wages and contribute to demand for goods and services.

Figure 2: **Liverpool City region, Greater Manchester City Region and North West of England**



The language of health and social care economy

A new body of words and phrases has been developed to mask and conceal the true intention of imposing new business values (Whitfield, 2006).

This study avoids the use of the misleading umbrella term 'independent sector', which primarily consists of private health and social care companies, and to a much lesser extent, non-profit social enterprises and voluntary organisations. Reference is made to each in specific circumstances. It also avoids the use of the generic term 'provider' and instead refers to in-house provision, private or non-profit contractors (voluntary organisations and social enterprises).

The transfer of NHS or local authority services to the private sector, social enterprises and mutuals means that staff are employed by these companies and are no longer public employees, nor the associated sale or transfer of property or equipment. This is privatisation. The term 'in-house option' must be a forward-looking plan based on innovation and improvement prepared and evaluated on the same basis as other options and must not be based on a 'status quo' or 'business as usual' approach. The language of commissioning is presented as an unbiased rational process of analysis, planning and reviewing, but is increasingly tied to a procurement process and a contract culture.

Part 2 Economic and social benefits of health and social care investment

Importance of the health and social care sector in the regional economy

Gross Value Added (GVA) measures the contribution to the economy of each individual producer, industry or sector in the UK. The North West had the third largest total regional GVA outside of London and the South East in 2013, although it ranked sixth on GVA per head of population (Table 2). The North West and Wales had the largest percentage increases in GVA per head, both at 3.4%, in 2013 (ONS, 2014a). GVA per head of population within the North West in 2013 varied widely between Warrington's £28,553 and Wirral's £12,482, one of the lowest in the UK.

The health and social care economy accounted for 8.6% of the region's wealth in 2012, the fourth highest sector after manufacturing, wholesale and retail trade and real estate activities (Table 3). It had the largest percentage increase (1.8%) in the share of Gross Added Value of all sectors in the North West since 1997, offsetting the significant reduction of GVA in manufacturing and smaller decreases in transportation and in the electricity and gas supply sectors. The North West was the third largest region for employment in England, Wales and Scotland in 2014. It had the largest number of manufacturing jobs and the third largest service sector jobs (Figure 3).

GVA is measured in three ways. The *'production approach'* to estimating GDP looks at the contribution of each economic unit by estimating the value of an output (goods or services) less the value of inputs used in that output's production process. The *'income approach'* measures the incomes earned by individuals (for example wages) and corporations (for example, profits) in the production of outputs (goods or services). The *'expenditure approach'* measures total expenditure on finished or final goods and services produced in the domestic economy).

The relationship between the quality of employment and quality of service

There is conclusive evidence of a connection between the wellbeing of healthcare staff and the quality of care patients receive and their health outcomes. NHS employers that have addressed excessive hours, bullying, harassment and stress have better attendance, lower staff turnover, less agency spend, higher patient satisfaction and better outcome measures (Department of Health, 2009a; Raleigh et al, 2009; Dawson, 2009).

> *"NHS organisations must invest in the health and well-being of their workforce if they are to deliver sustainable, high-quality services"* (Department of Health, 2009a).

The Royal College of Nursing overview of research reports that better working conditions of nurses can be linked to positive outcomes in terms of patient safety; the reduction of medication errors (Needleman et al., 2002), the occurrence of pressure ulcers (Westwood et al., 2003); reductions in re-admission rates (Hewitt et al., 2003), the occurrence of complications such as pneumonia (Needleman et al., 2002; Hewitt et al., 2003); reductions in falls (Commonwealth Steering Committee for Nursing and Midwifery, 2003) and health care associated infections (Needleman et al., 2002; Aitken et al., 2003).

Sustaining good working conditions for nurses is crucial to increase retention, enhance performance and productivity and promote safe nursing care (Almalki et al, 2012). Empirical analysis shows a direct and positive relationship between employee satisfaction and the quality of hospital patient experience (Peltier et al, 2009).

The terms and conditions, training and progression and how staff are valued has an impact on sickness absence, recruitment, retention and HR costs (Owens et al, 2014; Devins et al, 2014; Cavendish Review, 2013). Furthermore, several local authorities responding to the Equality and Human Rights Commission (2011) investigation into social care *"...identified the poor pay and conditions of home care workers as a key barrier to promoting human rights. The effect on staff retention, training levels and the quality of staff attracted to the industry all have a knock-on effect on older people."* However, other research has not found conclusive evidence of a direct causal relationship between staff terms and conditions, increased performance and quality of care.

Table 2: **Workplace based Regional Gross Added Value 2013 at current basic prices**

Nine English Regions, Scotland, Wales and N. Ireland	Total GVA (£m)	Share of UK total GVA (%)	GVA per head (£)	GVA per head indices
London	338,475	22.2	40,215	171.0
South East	227,232	14.9	25,843	110.5
North West	**141,620**	**9.3**	**19,937**	**85.2**
East of England	130,378	8.6	21,897	93.6
Scotland	117,116	7.7	21,982	94.0
South West	113,806	7.5	21,163	90.5
West Midlands	110,246	7.2	19,428	83.0
Yorkshire & The Humber	101,701	6.7	19,053	81.4
East Midlands	88,835	5.8	19,317	82.6
Wales	52,070	3.4	16,893	72.2
North East	45,374	3.0	17,381	74.3
Northern Ireland	32,841	2.2	17,948	76.7
Cannot be allocated	23,107	1.5		
UK	**1,525,304**	**100.0**	**23,394**	**100.0**

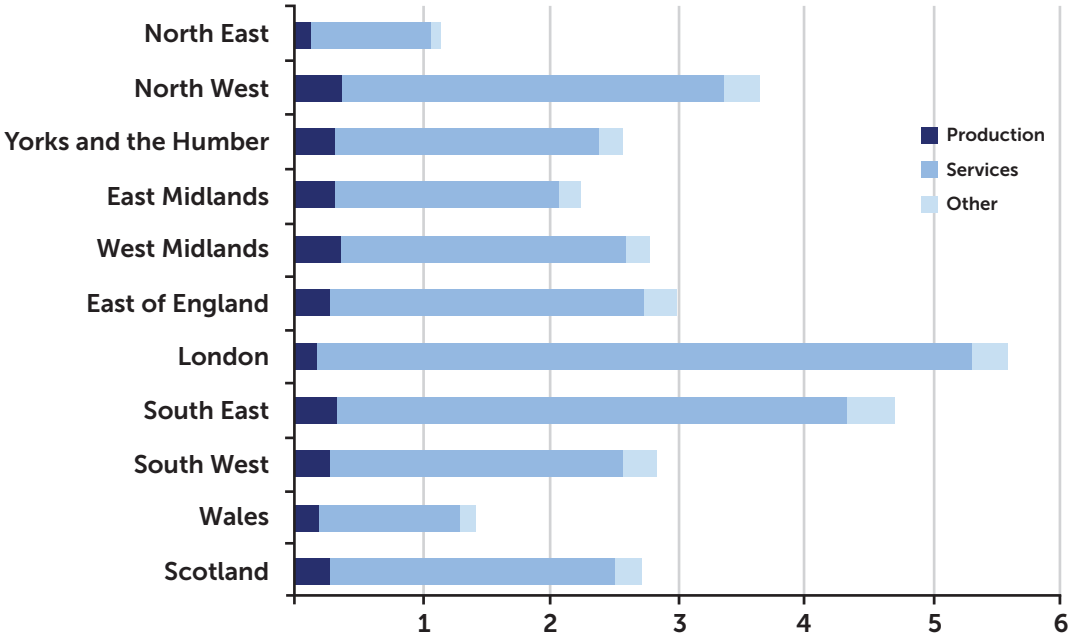
Source: Office for National Statistics, 2014a.

Table 3: **Gross Value Added by industry sector in North West 2012**

Industry sector	£m	(%) 2012
Manufacturing	19,136	14.0
Wholesale & retail trade, repair of motor vehicles	15,527	11.4
Real estate activities	14,609	10.7
Human health and social work activities	**11,763**	**8.6**
Education	9,910	7.2
Professional, scientific and technical activities	9,297	6.8
Construction	8,653	6.3
Finance and insurance activities	7,868	5.8
Administrative and support service activities	6,810	5.0
Public administration & defence, social security	6,646	4.9
Information and communication	6,168	4.5
Transportation and storage	6,082	4.4
Accommodation and food services	4,370	3.2
Other service activities	3,225	2.4
Arts, entertainment and recreation	2,106	1.5
Electricity, gas, steam and air conditioning supply	1,716	1.2
Water supply, sewage, waste management	1,439	1.1
Agriculture, forestry and fishing	781	0.6
Activities of households	424	0.3
Mining and quarrying	109	0.1
Total	**136,641**	**100.0**

Source: Office for National Statistics, 2014a.

Figure 3: **North West third largest region for employment (September 2014)**



Source: Office for National Statistics, 2015a.

A strong relationship has been established between a high level of employee engagement and patient centred care, quality and safety outcomes, patient satisfaction and improved productivity (Lowe, 2012; Peltier et al, 2009; West et al, 2011). 'Engagement' can be defined to include psychological engagement (a positive, fulfilling, work-related state of mind) and organisational commitment (West and Dawson, 2012). The Review of Staff Engagement and Empowerment in the NHS (2014) draws heavily on this definition to demonstrate highly engaged employees are:

- healthier and happier, with lower sickness absence and lower staff turnover;
- are more likely to deliver high-quality care;
- have fewer accidents, make better use of resources, and deliver better financial performance;
- are more likely to think creatively and innovate at work;
- should be more likely to have the necessary psychological resources to show empathy and compassion to patients, despite the challenges of working in pressured environments and risk of compassion fatigue;
- are more likely to intervene to raise concerns about safety or address poor behaviours.

Three important conclusion are evident.
Firstly, pay and benefits are rarely included in research studies concerning the wellbeing of health and social care staff or included in healthcare workplace frameworks for improving the quality of care.

Secondly, the health and wellbeing of the workforce includes their involvement in the planning, delivery and improvement of services,

Thirdly, a narrow definition of engagement predominates with staff and trade unions rarely involved in the planning, delivery and improvement of services on a continuing basis. This is despite the NHS Constitution pledging:

> *"...to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families"* (NHS England, 2013).

Advantage of a health and social care economy approach in the North West

The health and social care economy approach has several key advantages for NHS Trusts, CCGs, primary care and local authorities.

Firstly, this approach encourages a more holistic perspective of patient/community needs, organisational

and political boundaries to seek solutions to peoples needs. It can accelerate collaboration and ultimately service coordination and integration between neighbouring local authorities and city regions.

Secondly, it can influence the planning, design and funding of projects and can help to ensure they are more flexible and responsive. Services or projects that have wider political, organisational and management support means they are harder to reduce or dismantle.

Thirdly, the health and social care economy approach can strengthen the commitment to tackling inequalities because more cross-cutting, budget pooling and service integration raises new challenges in how to tackle inequalities and makes their marginalisation or 'parking' more difficult.

Fourthly, projects are more likely to be subjected to full evaluation and impact assessment so that the participant contributions can be valued. It is important that the 'future return' is comprehensive and not limited to financial or social 'rate of return'.

Finally, this approach has the potential for building wider community and public support for the NHS and social care.

Key changes in the health and social economy in the last decade

There have been significant changes in the health and social care economy since the original Health and Social Care Economy in the North West analysis was published in 2003.

Investment in the NHS increased in real terms until the recession caused by the global financial crisis began in 2008.

Coalition austerity policies since 2010 included deep public spending cuts which led to big reductions in local authority social care provision and other services, although the NHS budget was given a degree of protection.

The Coalition's austerity policies increased income and health inequalities.

Marketisation and privatisation of NHS services has accelerated with the growth of Independent Treatment Centres, outsourcing and transfer of services to private and voluntary sector contractors, and government-promoted social enterprises and mutuals.

The privatisation of social care accelerated as local authorities sold care homes and increasingly outsourced the provision of home care.

The commissioning model (the separation of purchaser and provider functions) was embedded in the NHS and increasingly in local government. Reliance on PFI increased - the capital value of major healthcare PFI projects in the North West increased from £765m in 2003 to £1,909m in 2014. In addition, seventy-nine privately financed primary healthcare infrastructure projects were completed in the region at a total capital cost of £600m.

The personalisation and choice agenda continued with the emphasis on patients as consumers.

Obesity of adults and children has risen rapidly imposing additional demands on the NHS.

Significant changes have been made in the structure and organisation of health and social care since 2003 with the abolition of Primary Care Trusts and Strategic Health Authorities, which were replaced by Clinical Commissioning Groups, supported by Commissioning Support Units.

The North West Regional Development Agency and North West Regional Assembly were abolished by the Coalition government in 2011 resulting in the loss of regional economic and spatial planning.

City Regions and their respective Combined Authorities have developed in Liverpool and Manchester.

Awareness of demographic change has increased, particularly the ageing of the population. Changes have been made to regulatory regimes following several health and care scandals, but gaps and weaknesses remain.

Part 3 Public spending in health and social care economy

Health expenditure in the North West

North West health expenditure in 2013-2014 was £15.1bn, the third highest level in the nine English regions (Table 4). It had the second highest expenditure per head at £2,156 in 2012-2013 (Department of Health, 2014).

Table 4: **Health expenditure by region 2013-2014** (£m)

Region	2010-2011 (£m)	2013-2014 (£m)	% of 2013-2014
North East	5,891	5,611	5.5
North West	**14,182**	**15,116**	**14.8**
Yorkshire and the Humber	9,735	10,523	10.3
East Midlands	7,700	8,480	8.2
West Midlands	10,450	10,971	10.7
East of England	10,009	10,278	10.0
London	16,446	16,688	16.3
South East	14,418	15,126	14.8
South West	8,745	9,657	9.4
Total	**97,570**	**102,451**	**100.0**

Source: Department of Health, 2014.

Personal social service expenditure was £17,250m in 2013-2014 (Table 5). Residential provision and day and domiciliary services accounted for the nearly 90% or expenditure. People over 65 accounted for 43% of residential provision, 40% of day and domiciliary services and 52% of assessment and care management.

Table 5: **Gross current expenditure by client type and type of provision, England, 2013-2014**

Category	Assessment & care management (£m)	Residential provision (£m)	Day & domiciliary provision (£m)	Total expenditure (£m)
Service strategy	50	-	-	50
Older people (65 and over)	980	4,720	3,150	8,850
Adults with physical disabilities (18 to 64)	220	360	1,010	1,590
Adults with learning disabilities (18 to 64)	290	2,060	3,030	5,380
Adults with mental health needs (18 to 64)	310	350	450	1,110
Asylum seekers	-	-	10	10
Other adult services	30	-	240	260
Total gross current expenditure	**1,880**	**7,490**	**7,880**	**17,250**

Source: HSCIC, 2014a.

UK public spending plans

The Coalition government's Autumn Statement 2014 forecast, that total public spending is set to fall to 35.2% of GDP in 2019-2020 (Figure 4) and below previous post-war low and *"...to what would probably be its lowest level in 80 years"* (Office for Budget Responsibility, 2014).

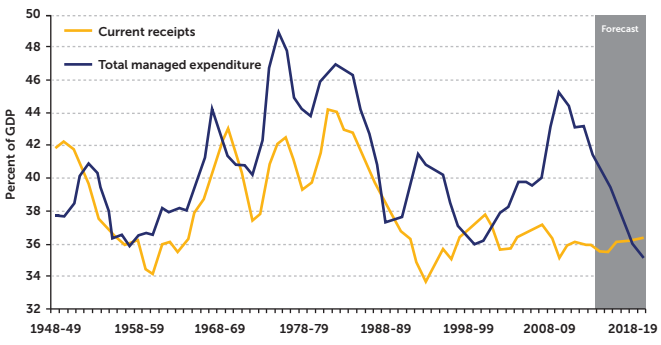
The OBR's analysis finds *"...the figures imply that roughly 40 per cent of the total implied cut in day-today public services spending between 2009-10 and 2019-20 will have taken place over this Parliament, with roughly 60 per cent to come in the next"* (ibid).

In other words, 60% of the planned cuts have yet to be imposed and are planned between 2015-2020. The government has not set out detailed spending plans beyond 2015-2016, so it is not possible to assess the impact on particular services.

The Institute for Fiscal Studies forecast, that if Labour had won the 2015 election they would have kept borrowing to pay for investment spending i.e. about £25bn per annum. This would have required spending cuts or tax increases of about £7bn after 2015-2016. The Conservative government plans a budget surplus and will not borrow to invest, so spending cuts of about £33bn are planned after 2015-2016 (Institute for Fiscal Studies, 2015). Prime Minister David Cameron promised £7.2bn tax cuts by 2020 under a future Conservative government (Financial Times, 2014).

In these circumstances, talk of 'after austerity' is illusory.

Figure 4: **Total public spending and receipts**



Source: ONS. OBR

The 2015 Budget made small changes to departmental expenditure limits to 2018-2019, for example, the 2016-2017 cuts target was reduced from £25.8bn to £22.6bn and from £41.4bn to £38.6bn in 2017-2018 (Giles, 2015).

Impact of austerity policies

Five years of austerity policies has led to falling economic output, which only recently began to increase in the UK; mass unemployment; public sector job losses up to 1.3m by 2020; cuts or wage freezes; cuts in benefits; closures and business failures; increasing poverty and widening inequality across the EU and North America (Whitfield, 2014a). Furthermore, public debt continued to increase, demand slumped and investment and growth has been weak in Europe. Output has increased in the UK and Ireland, but it remains weak, particularly with global growth forecasts being revised downwards despite cheaper oil and faster US growth (International Monetary Fund, 2015).

Austerity policies have had a major impact on health and social care:

- Increased poverty and homelessness resulting in greater risk of illness;
- Greater risk of mental health problems and an increase in suicide and alcohol-related death rates;
- Increased fuel poverty, which is linked to respiratory and cardiovascular disease, to exacerbating existing health problems such as asthma, bronchitis and arthritis;
- Higher user charges for disability services and social care; (detailed evidence in Stuckler and Basu, 2013 and Winters et al, 2012).

Nationally, disabled people have borne the brunt of cuts:

- *"People in poverty (21% of the population) bear 39% of all cuts.*
- *Disabled people (8% of the population) bear 29% of all cuts.*
- *People with severest disabilities (2% of the whole population) bear 15% of all cuts*
- *People in poverty will lose an average of £2,195 per person, per year - this is 5 times more than the burden placed on most other citizens.*
- *Disabled people will lose an average of £4,410 per person - this is 9 times more than the burden placed on most other citizens.*
- *People with severe disabilities will lose an average of £8,832 per person - this is 19 times more than the burden placed on most other citizens"* (Duffy, 2013).

Financial health of NHS trusts

In 2013-14 twenty-one NHS trusts and ten foundation trusts received £511m in cash support from the Department of Health, a 94.3% or £248m increase compared to 2012-13 (National Audit Office, 2014a). The Department provides cash support in the form of revenue-based public dividend capital (PDC) to enable trusts having financial problems to pay creditors and staff. The Department of Health issued £1.8bn revenue based PDC over the last eight years, of which only £160m has been repaid (ibid). NHS trust deficits continue to rise, with a combined deficit of £630.2m halfway through the 2014-15 financial year. Eighty-one, or 55%, of the 147 foundation trusts in England had a £396m deficit, offset by 66 trusts having a surplus of £142m in the same period, a net deficit of £254m by the end of September 2014 (Monitor, 2014a). The health budget was increased by a further £740m in December 2014 to help NHS Trusts in financial crisis. The Treasury injected £250m and allowed a £490m transfer to the revenue budget from the Department of Health's capital budget (Health Service Journal, 2014).

North West Trusts in crisis

University Hospitals of Morecambe Bay NHS Foundation Trust (Table 6) was one of four foundation trusts that had deficits of more than £10m in both 2012-2013 and 2013-2014 (National Audit Office, 2014a). The Trusts Operational Plan 2014-2016 reported the Trust was *"...evaluating the potential to establish "partnering" arrangements with other providers. This may include outsourcing of non-core services, franchising of services at Trust sites, or other collaboration arrangements with other providers"* (UHMB, Operational Plan, 2014).

The Operational Plan 2014-2016 conceded that research *"...is now producing the evidence that operating as we do, across three main sites, with relatively low volumes and across a wide geographical area is unsustainable and cannot continue"* (ibid). This was reported by the NAO financial sustainability study without comment.

Table 6: **North West NHS Trusts with deficits greater than £10m or 5% of their income 2013-2014**

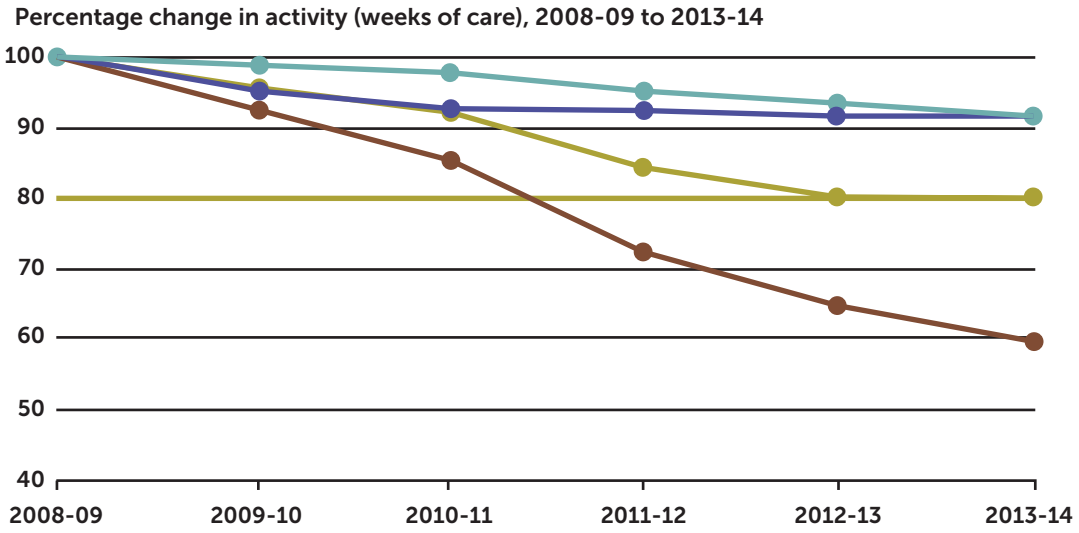
Trust	Type of trust	Surplus or deficit 2012-2013	Deficit 2013-2014	Deficit 2013-2014, as percentage of operating income (%)	Planned surplus or deficit 2015-15
North Cumbria University Hospitals	Non-FT	0.2	-27.1	-11.8	-26.3
University Hospitals Morecambe Bay	FT	-23.2	-18.8	-7.0	-19.0

Source: National Audit Office, 2014c.

Further large cuts in local authority expenditure

The National Audit Office estimated a 37% real-term reduction in government funding to local authorities between 2010-2011 and 2015-2016 and 16.6% reduction in full-time equivalent posts (excluding the total school workforce) between 2010 and 2013. However, this was prior to the Autumn Statement and the financial settlement for local government in December 2014 (National Audit Office, 2014b). The NAO analysis of the percentage change of activity in weeks of care revealed that day care has reduced by 40% and home care by nearly 20% (Figure 5). Residential and nursing care activity in weeks of care reduced by nearly 10%. The situation has since deteriorated as a result of further spending cuts in 2014-15 and 2015-16.

Figure 5: **Change in local authority activity in adult social care 2008-09 to 2013-14**



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Residential care	100	98.63	98.71	95.05	93.18	91.52
Nursing care	100	95.14	92.44	92.58	91.64	91.59
Homecare	100	95.93	91.87	84.27	80.37	80.37
Day care	100	92.67	85.34	72.33	64.64	59.59

Source: National Audit Office, Financial sustainability of local authorities 2014, Figure 4.

The 2015-16 Local Government Financial Settlement imposed an average cut of 1.8% on local authority revenue spending. The spending power of local authorities in London will be cut by an average 4.3%, metropolitan authorities by an average 3.3% and county councils by an average 0.6%. The average figures masked large reductions in Knowsley, Liverpool and Manchester of 6.0%, 5.9% and 5.1% respectively (Department for Communities and Local Government, 2014a). The North West average was 3.05% compared with a 1.4% increase in Cheshire East (Table 7). The national average rises to 6% when ring fenced funds and pooled resources are excluded (Chartered Institute for Public Finance & Accountancy, 2014)

The Chartered Institute for Public Finance & Accountancy (CIPFA) analysis reveals that reduced spending power in 2015-16 will be even more severe in Knowsley, Liverpool and Manchester with -10.9%, -10.7% and -10.5% respectively – three North West local authorities in the four largest falls in spending power nationally.

The Local Government Association (LGA) reported the national average reduction was 8.8% when the elements of the Better Care Fund are excluded (Local Government Association, 2014a).

"The cut announced today brings the total reduction in core government funding to councils since 2010 to 40 per cent. Over this period councils will have made £20 billion worth of savings" (LGA, 2014b).

Table 7: **The impact of 2015-2016 spending cuts on North West local authorities**

Local authority	Political control	% change 2015-16
Knowsley MBC		-6.0
Liverpool City Council		-5.9
Manchester City Council		-5.1
Blackburn Council		-4.8
Blackpool Council		-4.7
Oldham MBC		-4.5
Rochdale MBC		-4.4
Halton BC		-4.2
Tameside MBC		-3.8
Bolton MBC		-3.7
St Helens MBC		-3.1
Sefton MBC		**-2.9**
Wirral MBC		-2.7
Wigan MBC		-2.5
Bury MBC		-2.3
Stockport MBC	NOC	-1.1
Lancashire	NOC	-0.7
Trafford MBC		-0.7
Cumbria	NOC	-0.6
Warrington		-0.4
Cheshire West & Chester		0.0
Cheshire East		1.4

Source: Local Government Association, 2014b

Chronic underfunding of social care

Local authorities will have to divert £1.1bn from other services in order to fund adult social care funding. Local authority spending on adult social care, £14.6bn in 2014-2015, now represents 35% of local government spending compared to 30% in 2010-2011 (Local Government Association, 2015a). The LGA conclude: *"Rapidly rising demand means that even with councils protecting social care from cash cuts, the provision of care is having to be cut back to make ends meet"*

The LGA has earlier warned:

> *"...the health and social care system is chronically underfunded. It is social care services that support elderly and vulnerable people to maintain their independence, live in their own community and stay out of hospital longer, which is why investing in social care is a crucial part in alleviating the pressures on the health service. Investing extra money in the NHS while forcing councils to cut their social care budgets is simply a false economy and will not solve this ever-growing problem"* (LGA, 2015b).

Better Care Fund

The Fund was launched to pool NHS and local authority funding in a locally led programme to integrate health and social care services in 2015-2016 and beyond. The Fund consists of funds reallocated from existing budgets, rather than new money. The initial management of the programme was inadequate and the assumption of a £1bn savings for the NHS in 2015-2016 was not communicated to local authorities and CCGs (National Audit Office, 2014c). Bids totalling £5.5bn had to be revised and reassessed. *"So the priority has shifted from improving local services through integration to protecting NHS resources"* (House of Commons Committee of Public Accounts (2015). The Committee are *"...not convinced that it is possible to reduce emergency admissions and deliver £532 million of savings in 2015-16."* Furthermore, £253m of the NHS contribution to the Fund is conditional on achieving the savings from reduced hospital emergency admissions.

Implementation of the Care Act 2014

The implementation of the Care Act 2014 will, in the context of current expenditure plans, have to take account of:

- Public expenditure cuts that could be larger than those imposed in the 2010-2015 period;
- An additional loss of 1m public sector jobs;
- Continued 'protection' of the NHS in the allocation of public expenditure, but the demand for efficiency 'savings' is bound to intensify, and there is no substantive commitment to curtail marketisation and privatisation;
- Local government is in a deep financial crisis and, because adult social care is a significant proportion of local authority budgets, further cuts in care are inevitable;
- Spending plans after 2015 will have to take account of the unmet need for care arising from earlier substantial cuts in care budgets since 2010-11.

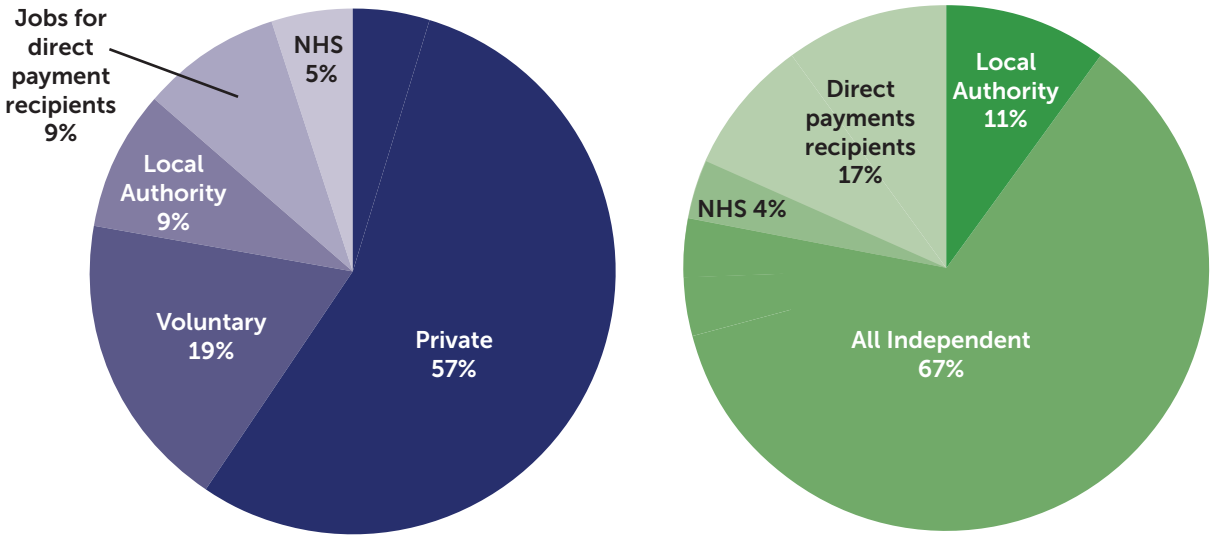
This is not a context in which the Care Act 2014 can be effectively implemented.

Part 4 Health and social care employment in the North West

This section of the analysis identifies employment in various sections of health and social care, which is used to identify the employment in companies and organisations supplying goods and services to the NHS and local authorities (indirect employment). The earnings from direct and indirect jobs create additional employment when household income is spent in the local and regional economy.

The local authority and NHS share of employment in the North West is very similar to England, but the North West has almost twice the employment in direct payments and 67% private and voluntary sector employment compared to 76% in England (Figure 6).

Figure 6: **Differences in England and North West social care jobs by type of employer** (2013)



Source: Skills for Care, 2013a and 2013b

Direct employment in public sector health and social care

The North West had 439,600 jobs in the health sector in 2013, accounting for 14.5% of regional employment, and significantly the largest sector ahead of manufacturing and retail sectors (Table 8). Just over half the jobs were in the public sector (224,600) with a further 215,000 in the private sector.

Table 8: **Public and private employment by sector in North West in 2013**

Broad Industry Group	Full & Part time employees (000)			% of Total regional employment
	Public	Private	All	
Health	**224.6**	**215.0**	**439.6**	**14.5**
Agriculture, Forestry & Fishing	*	*	13.2	0.4
Mining, Quarrying & Utilities	3.8	32.6	36.3	1.2
Manufacturing	*	*	306.0	10.1
Construction	2.6	138.6	141.3	4.7
Motor Trades	0.2	47.2	47.4	1.6
Wholesale	*	*	133.6	4.4
Retail	0.1	308.7	308.7	10.2
Transport & Storage (inc Postal)	21.4	122.3	143.7	4.7
Accommodation & Food Services	3.3	195.1	198.4	6.5
Information & Communication	2.5	80.6	83.1	2.7
Finance & Insurance	14.7	84.5	99.2	3.3
Property	2.3	51.9	54.2	1.8
Professional, Scientific & Technical	3.8	225.4	229.2	7.6
Business Administration & Support Services	8.0	235.4	243.4	8.0
Education	171.6	103.0	274.6	9.1
Public Admin	148.8	1.3	150.0	5.0
Other	10.6	115.9	126.5	4.2
Total	**629.4**	**2,466.0**	**3,028.4**	**100**

Source: ONS: Notes: Part time is working less than 30 hours per week, full time over 30 hours per week.
Public sector comprises central government, local government and public corporations.
Private sector comprises companies, sole proprietors, partnerships and non-profit bodies.

Six out of ten jobs (61.1%) in health in the public sector are full-time jobs compared to 51.9% in the private sector (Table 9).

Table 9: **Health sector and total North West employment,** 2013

Sector	Full time		Part-time employees		Total employment		Total
	Public	Private	Public	Private	Public	Private	
Health (000)	136.9	115.4	87.7	99.6	224.6	222.4	**447.0**
North West (000)	393.9	1,662.2	234.7	737.7	629.4	2,497.8	**3,127.2**
% of North West jobs	34.7%	6.9%	37.4%	13.5%	35.7%	8.9%	

Source: Office for National Statistics, 2014b, Table 4.

The NHS employed 15,511 medical staff in the North West in July 2014 with just over 4,000 staff employed in the Liverpool City Region and in Cumbria, Lancashire and Cheshire areas. The Greater Manchester City Region accounted for nearly half the regions medical staff (Table 10).

NHS non-medical employment totalled just over 166,000 in the North West in July 2014 (Table 11). Liverpool City Region had just over 40,000 employees in this category with Greater Manchester and Cumbria, Lancashire and Cheshire areas each having over 60,000.

This data is inclusive of 1,930 jobs in Clinical Commissioning Groups in the North West divided amongst 160 in Sefton, 483 in Liverpool City Region, 917 in Greater Manchester City region and 450 in Cumbria, Lancashire and Cheshire areas.

The non-medical workforce included 10,669 NHS staff employed in cleaning, catering, portering and other support services (Table 10). The data should be read in conjunction with NHS facilities management outsourcing contracts (Table 45). Ten of the 41 Trusts directly employed less than a hundred staff, including several with virtually no directly employed support staff.

Table 10: N**HS medical and non-medical employment in North West region, July 2014**

Local Authority/City Region	**Medical employment**		**Non-Medical employment**	
	FTE	**Estimated Headcount** (1.12 ratio jobs to FTE)	**FTE**	**Headcount**
Sefton	309.0	346*	3,000	3,450*
Liverpool City Region	3,735.4	4,184	35,285	40,578
Greater Manchester City Region	6,314.8	7,073	55,875	64,257
Cumbria, Lancashire and Cheshire areas	3,798.4	4,254	53,701	61,756
North West region	**13,848.6**	**15,511**	**147,861**	**166,591**

Source: HSCIC, 2014a. * Sefton included in Liverpool City Region total.

GP practices

GP practice staff data includes all categories of nurses employed by the practice, plus health care assistants, physiotherapists, pharmacist, chiropodists, dispensers, counsellors, complementary therapists and other involved in direct patient care (Table 11). Administrative staff, such as practice managers, receptionists, secretaries, other office staff and cleaners, are also included.

Dentists

Nearly three thousand dentists provided NHS treatment in the North West in 2013-2014 (Table 11). They treated 3.0m adults and 1.1m children in the previous twenty-four months to 31 March 2014. The number of staff employed in dental practices is not available. There are variations in the type of dental contract and types of practice. However, self-employed primary care dentists in the North West incurred average non-clinical employee costs of £29,400 in 2011-2012 (33% of expenses). This excludes employed or self-employed hygienists and therapists (HSCIC, 2011, Table 34). The average number of non-clinical dental practice staff is estimated to be 1.5% NHS/Private work.

Opticians

The General Ophthalmic Services provides (via high-street opticians) preventative and corrective eye care for children, people aged 60 and over, people on low incomes and those suffering from or are pre-disposed to eye disease. Statistics on practice staffing levels are not available, but is estimated to be an average of two additional staff per ophthalmic practitioner (Table 11).

Table 11: **GP, Dentists and Opticians and practice staff in the North West**

GP and practice staff

Local Authority/City Region	No of GPs (Headcount)	Practice staff (Headcount)	Total	Total FTE
Sefton	174	710	884*	
Liverpool City Region	1,102	4,054	5,156	
Greater Manchester City Region	1,988	6,992	8,980	
Cumbria, Lancashire and Cheshire areas	2,550	7,588	10,138	
North West region	**5,640**	**18,634**	**24,274**	**20,564**

Dentists and practice staff

NHS CCG areas	No. of Dentists	Practice staff	Total	Total FTE
South Sefton & Southport & Formby CCGs	192	288	480*	
Liverpool City Region	844	1,266	2,110	
Greater Manchester City Region	1,340	2,010	3,350	
Cumbria, Lancashire and Cheshire areas	1,605	2,407	4,012	
North West region	**3,789**	**5,683**	**9,472**	**8,119**

Opticians and practice staff

NHS PCT areas	No. of Ophthalmic Practitioners	Practice staff	Total	Total FTE
Sefton PCT	41	82	123*	
Liverpool City Region	275	550	825	
Greater Manchester City Region	594	1,188	1,782	
Cumbria, Lancashire and Cheshire areas	659	1,318	1,977	
North West region	**1,528**	**3,056**	**4,584**	**3,911**

Source: GP and practice staff – HSCIC, 2014b, 2003-2013.

Source: Dentists and practice staff – HSCIC, 2014c, 2013-2014.

Source: Opticians and practice staff – HSCIC, 2014d.

* Sefton included in Liverpool City Region total. FTE derived from 1.12 multiplier for m medical staff and 1.20 for practice staff.

Public Health

Eleven core public health roles were identified by the Centre for Workforce Intelligence Mapping the Core Public Health Workforce. No regional breakdown of figures is currently available. The workforce figures in Table 12 were derived from the Centre's national estimates of the public health roles based on the North West population (7,103,300 or 13.2%) as a percentage of England's population of 53,865,800 (ONS, 2014c). Where estimates were within a range, a mid point was selected.

Table 12: **Public Health workforce in the North West**

Public Health roles	No of Jobs
Working at Public Health Skills and Knowledge Framework (PHSKF) levels 8 & 9	
Public health consultants and specialists (including registrars)	205
Directors of Public Health (DsPH)	*23
Public health academic	33
Public health managers	119
Working at PHSKF levels 5 to 9	
Public health scientists	264
Intelligence and knowledge professionals	152
Public health nurses	73
Working at PHSKF levels 5 to 7	
Health visitors	1,452
School nurses	528
Public health practitioners	1,320
Environmental health professionals.	924
Total	**5,093**
Total FTE based on 1.12 multiplier	4,547

Source: Centre for Workforce Intelligence, 2014. * Based on 23 Metropolitan Unitary and County local authorities in the North West.

Public Health staffing statistics are not available at a local level, so this has been estimated on a pro-rata population basis – Sefton has 193 Public Health employment, Liverpool City Region 1,085, Greater Manchester City Region 1,940 and Cumbria, Lancashire and Cheshire 2,068.

Social care

Sefton had the lowest level of directly provided local authority social care in the North West in 2013, which accounted for 4.1% of social care employment (Table 13). The Liverpool City Region share of local authority directly employment (8.0%) was significantly lower than Greater Manchester City Region and Cumbria, Lancashire and Cheshire at 14.9% and 14.4% respectively. This reflected the higher level of outsourcing of care services in the Liverpool City Region. Overall, local authorities employ only 13.2% of social care staff in the region.

Table 13: **Number of staff employed in local authority social care provision North West**

Local authority	Local Authority	Private & Voluntary sectors	Direct payment recipients	Total
Sefton	***400***	***7,600***	***1,400***	***9,400***
Liverpool	1,300	11,600	2,200	15,100
Knowsley	400	4,600	700	5,700
St Helens	700	5,100	600	6,400
Wirral	700	7,500	1,400	9,600
Halton	500	1,700	1,400	3,600
Liverpool City Region	**4,000**	**38,100**	**7,700**	**49,800**
Manchester	1,700	9,000	4,300	15,000
Bolton	1,200	4,200	1,800	7,200
Bury	1,700	3,800	600	6,100
Oldham	1,100	4,000	1,900	7,000
Rochdale	800	4,800	600	6,200
Salford	1,400	4,300	1,700	7,400
Stockport	800	5,600	1,400	7,800
Tameside	700	3,200	800	4,700
Trafford	600	3,900	1,800	6,300
Wigan	1,200	5,000	1,500	7,700
Greater Manchester City Region	**11,200**	**47,800**	**16,400**	**75,400**
Cumbria	3,700	12,700	1,300	17,700
Lancashire	4,600	30,300	4,000	38,900
Warrington	800	4,500	500	5,800
Blackburn with Darwen	400	3,000	300	3,700
Blackpool	1,000	3,600	600	5,200
Cheshire East	1,600	8,400	2,900	12,900
Cheshire West & Chester	1,500	6,200	1,700	9,400
Cumbria, Lancashire & Cheshire areas	**13,600**	**68,700**	**11,300**	**93,600**
Total	**28,800**	**154,600**	**35,400**	**218,800**
Total FTE based on 1.20 multiplier	24,000	128,833	29,167	182,000

Source: Skills for Care, 2013b. * Sefton included in Liverpool City Region total

North West local authorities currently directly employ just over 25,000 staff delivering adult social care services (Table 14). It reveals the extent to which several local authorities (Sefton, Wirral, Manchester, Oldham, Stockport and Warrington) did not employ any directly employed staff in domiciliary care and others employed very few (Liverpool, Knowsley, Blackburn and Blackpool). Sefton did not have directly employed staff in residential care and day care. The total varies with Table 13 due to different data sources.

Table 14: **Local authority staff employed in adult social care, North West region**

Local authority	Residential	Day Care	Domiciliary	Community	Other	Total
Sefton	0	0	0	215	135	350*
Liverpool City Region	765	755	345	1,500	770	4,145
Greater Manchester City Region	2,055	830	1,705	3,830	1,950	10,370
Cumbria, Lancs % Cheshire areas	4,185	1,725	970	2,570	1,660	11,125
Total	**7,005**	**3,310**	**3,020**	**7,915**	**4,380**	**25,655**

Source: HSCIC, Personal Social Services, 2014a. Totals may not sum due to rounding.

* Sefton included in Liverpool City Region total

Direct employment in other companies and organisations providing health and social care

Local authority Trading Companies

Three Local Authority Trading Companies (LATC) were established in the North West for social care services, although the Stockport LATC ceased trading on 31 March 2014 (Table 15). LATCs are separate local authority owned companies that employ staff and deliver services. Staff in LATCs are included in the local authority social care staffing statistics.

Table 15: **Health & social care Local Authority Trading Companies in North West**

Local authority	Name	Date established	Services	No of Staff
Sefton MBC	New Directions	2007	Adult social care	320
Oldham MBC	Oldham Care and Support Ltd	2013	Adult social care	450
Stockport MBC	Individual Solutions SK	2009	Adult social care services transferred back in-house January 2013, meals in-house March 2014	200
Total				**970**

Source: Local authority reports

Private hospitals, clinics, nursing and care homes

The public sector provides the bulk of acute medical/surgical hospital care and community mental health and learning disability services. They also provide the majority of special education and children's care, community health and home healthcare, mental health and learning disabilities hospital sector and non-residential social care services such as day care (Table 16). However, the private and voluntary sectors provide the bulk of services to primary medical care, residential care homes for elderly, physical and learning disabilities and mental health, and dental services.

Table 16: **Proportion of health and social care provided by independent sector in UK, 2011**

Health and Social Care Sector	Public sector supply (%)	Proportion provided by private and voluntary sector (%)	Proportion provided by four largest independent operators (%)	Total supply in UK 2011 (£bn)
Care homes for older and physically disabled people	14	86	19	14.5
Dental services	5	95	10	6.0
Special education and children's care	77	23	13	8.5
Acute medical/surgical hospital sector	93	7	61	56.8
Learning disabilities/mental health care homes sector	18	82	7.5	4.7
Domiciliary social care and supported living	17	83	11	6.9
Other non-residential social care services (daycare, meals)	67	33	n/a	4.7
Community health and home healthcare	75	25	47	11.2
Primary medical care (GPs & out of hours services)	4	96	2	11.7
Mental health and learning disabilities hospital sector	71	29	56	3.8
Community mental health and learning disabilities sector	99	1	n/a	12.1
Total				**140.9**

Source: The Role of Private Equity in UK Health & Care Services, Laing & Buisson, July 2012.

Subsequent figures indicate that the private/voluntary sector share of domiciliary social care has risen to 83% to 86% and care home provision for the elderly, learning disabilities and mental health had increased to 90% in 2013 (Laing & Buisson, 2014a).

The allocation of employment to particular sectors is already blurred, for example, a large majority of GPs have been in private practice since the formation of the NHS. Some newly formed social enterprises running services transferred from NHS Trusts, are often treated as if they remain part of the NHS when clearly staff have a different employer.

There is a paucity of publicly available statistics on the size, scope, type and employment in the private healthcare at local, regional and national levels. Department of Health (2002) community care statistics covered the period to March 2001, but were 'discontinued'. This has led to a serious lack of publicly available data, such as the type of facilities, number of beds and staffing levels in private nursing and residential homes, hospitals and clinics.

In 2014 twenty-two private hospitals operated by national and international companies, together with an independent trust, provide 814 beds in the North West (Table 17). In addition there are a number of smaller private clinics. Care UK operates the Greater Manchester NHS Clinical Assessment & Treatment Centre, which operates from mobile units, health centres and GP practices. NHS Choose and Book account for 97% of patients. Care UK also operates the Rochdale Ophthalmology Clinical Assessment and Treatment Service in addition to 11 NHS Treatment Centres in other regions. The mental health division operates 14 recovery units in ten hospitals and four residential care homes in England, including two in the North West. The 23 hospitals are estimated to employ 5,100 staff (4,434.8 FTE based on 1.15 multiplier) taking account that most private hospitals do not have accident and emergency, research and teaching hospital functions.

Table 17: **Main private hospitals in the North West**

Company	No of hospitals	No of beds
Ramsey Health Care (Australia)	4	101
Spire Healthcare plc (plus 3 clinics)	6	262
BMI Healthcare Limited (General Healthcare Group – South Africa)	7	293
HCA International (USA) plus surgical and diagnostic centre	1	35
Nuffield	2	62
Priory Group	2	29
Fairfield Independent charity	1	32
Total	**23**	**814**

Source: Private health company websites, December 2014.

The analysis of nursing and residential care homes is based on 621 nursing homes and 1,431 residential care homes in the North West, half of which are located in the Liverpool and Greater Manchester City Regions (Table 18).

Table 18: **Private and voluntary sector nursing and residential care homes in the North West**

Local authority	Nursing homes	Residential Care homes	Total	Estimated nursing staff (FTE)	Estimated Care Assistants (FTE)	Total Staff (FTE)	Total No. of jobs
Liverpool City Region	155	296	451	3,358.5	7,175.0	10,533.5	13,189
Greater Manchester City Region	174	416	590	4,393.6	9,386.4	13,780.0	17,255
Cumbria	37	145	182	1,355.3	2,895.4	4,250.7	5,323
Lancashire	146	427	573	4,367.0	9,115.9	13,482.9	16,873
Cheshire local authorities	109	145	254	1,891.5	4,040.1	5,931.6	7,427
Total	**621**	**1,431**	**2,052**	**15,365.9**	**32,612.8**	**47,978.7**	**60,067**

Source: www.carehome.co.uk, North West. Staffing based on 1 Nursing staff per 4.7 beds and 1 Care Assistant per 2.2 beds and average 35 beds per home (Department of Health, 2003). Conversion to number of jobs – 1.15 multiplier for nursing staff and 1.30 multiplier for care assistants.

Medical education employment

Medical and dental schools have an important role in training and research in the health and social care economy (Table 19). Twelve universities employ 1,940 academic staff in medicine, dentistry, nursing, midwifery, public health, mental health and social care undergraduate and postgraduate courses. A further 970 staff are estimated employed in support roles and thus a total of 2,910 staff engaged in health and social care education in the region (converted to 2,530 FTE in Table 29).

Students on medical, dental and health undergraduate and postgraduate courses contribute to the regional economy, but in effect 'replace' North West students who attend universities in other regions, so there is no net gain.

Table 19: **Employment in medical, dental and healthcare education in North West region**

Medical school	No of academic staff (Headcount)
Liverpool School of Tropical Medicine	318
University of Liverpool	280
John Moores University	152
Liverpool Hope University	26
Sub total Liverpool City Region	**776**
University of Manchester	303
Manchester Metropolitan University	166
University of Bolton	16
University of Salford	282
Sub total Greater Manchester City Region	**767**
Lancaster University	80
University of Cumbria	106
Edge Hill University	146
University of Central Lancashire	239
University of Chester	78
Sub total Cumbria, Lancashire & Cheshire areas	**649**
Total	**2,192**
Total FTE based on 1.12 multiplier	1,957

Source: University web sites and annual Financial Statements 2013-2014.

Research centres

The staff engaged in the regions biomedical research centres (see Part 8) are directly employed by the centres or by universities and NHS trusts. Others are independent non-profit organisations. In the absence of current health research employment data for the region and to avoid double counting, direct employment by public and private research organisations is estimated to be 2,000 jobs (1,739.1 FTE).

Voluntary sector provision of health and social care

Some 14,592 voluntary and non-profit organisations in Greater Manchester employed 23,600 FTE paid staff (34,200 employees) in 2012-2013 (Table 20). The statistics were compiled from seven separate studies for each local authority area in the city region (Centre for Regional Economic and Social Research, 2013). The health and social care sector was estimated to account for 30% of the total voluntary and non-profit sector employment. This includes 36 hospices in the region.

The North West voluntary and non-profit sector is estimated to have employed 18,583 FTE (26,929 jobs) in health and social care in 2012-2013, assuming that Liverpool City Region, Lancashire, Cheshire and Cumbria have a similar pattern of voluntary sector employment as Greater Manchester.

Table 20: **Staff in voluntary sector and social enterprises engaged in health and social care** (2012-2013)

Local authority/region	FTE	No of Jobs
Sefton	***706***	***1,023***
Liverpool City Region	3,956	5,736
Greater Manchester City Region	7,080	10,260
Cumbria, Lancashire and Cheshire areas	7,547	10,933
North West region	18,583	26,929

Source: Centre for Regional Economic and Social Research, Sheffield Hallam University, 2013.

Public spending cuts since 2012-2013 have had a deep impact on voluntary organisations in virtually all local authorities, hence the employment levels in Table 20 are likely to be smaller, taking account further planned spending cuts in the 2015-2016 period and subsequent years.

NHS staff shortages and vacancy rates

Staff shortages have increased significantly in both the health and social care sectors in the North West. However, there is a paucity of reliable data on vacancy rates and is available for only some sections of the health and social care sector. However, there have been numerous media reports of staffing shortages and overseas recruitment campaigns alongside reports of large cuts in frontline staffing. Information on vacancy rates in outsourced services is very difficult to obtain, as contractors are reluctant to disclose this information (Table 21).

Table 21: **NHS nurse staffing establishment and vacancy rates 2014**

Employment status	North West		England	
	FTE	%	FTE	%
Established Posts	18,657.45		126,330.74	
Posts occupied by permanent staff	16,967.83	91.0	114,700.83	91.0
Post occupied by temporary staff	1,353.4	7.0	5,478.02	4.0
Posts occupied by agency staff	45.5	0.2	2,078.76	1.7
Posts remaining unoccupied after agency and temporary considered	484.44	3.0	5,000.57	4.0
Posts not permanently occupied - vacancy rate	1,883.34	10.0	12,566.35	10.0

Source: NHS Employers, May, 2014

Turnover rates of 24.0% and 12.8% for care workers and community support and outreach workers respectively in the North West in October 2013 reflects employment conditions in this sector (Table 22).

Table 22: **Turnover and vacancy rates in care service in the North West** (2013)

Care role	Turnover rate (%)	Vacancy rate (%)
All Job roles	18.6	5.1
Community Support & outreach Worker	12.8	6.9
Care Worker	24.0	5.1
Senior Care Worker	10.1	2.9
Social Worker	6.3	9.6
Supervisor	11.2	3.5
Registered Manager	10.4	1.7
Senior Management	9.2	2.0
NHS		
GP survey (2013)	n/a	7.9
Qualified Pharmacists	n/a	5.4
Qualified Pharmacy Technicians	n/a	5.5
Pharmacy Assistants	n/a	6.3

Source: Skils for Care – nmds-sc data set, October 2013. HSCIC, Personal Social Services, 2014;
NHS Pharmacy Education and Development Committee (2014), Pulse survey 2013,

Staff in outsourced contracts

Identifying the number of staff employed in outsourced contract is complex. They are, in effect, transfers from the NHS and local authorities to the private sector and double counting must be avoided. Firstly, there is no systematic collect of contract employment data. Information is limited to a few individual contracts. Secondly, much depends on the date of outsourcing and the date on which statistics are collected. For example, the staff employed in the list of outsourced NHS contracts between April 2013 and November 2014 (Part 5) are almost certain to be included in current statistics as NHS employees. Further investigation is needed to determine how different statistical sources classify outsourced employees to avoid double counting.

It has been possible to estimate, using the data in Tables 48 and 49, that private contractors employed 5,585 staff (4,654.2 FTE) in the North West 2013-2014 in delivering outsourced hard and soft facilities management services to NHS Trusts. Given the different outsourcing strategies by the 41 NHS Trusts and the wide range of facilities management services and their respective staffing levels, it is not possible to disaggregate the data.

Although outsourced staffing information is very limited, national evidence from outsourcing contracts reveal:

- Job losses and reduced terms and conditions lead to recruitment and retention problems, which can result in quality and service delivery problems;
- Reduced spending power of NHS or private sector staff has a knock-on effect resulting in fewer jobs in the local economy;
- Reduced earnings result in less government income from taxation and National Insurance contributions and increased government expenditure through tax credits and other benefits paid to those on low earnings (see Part 6).

The total direct employment in the health and social care workforce in the North West is 551,802 jobs or 460,334.4 FTE (Table 23). This figure is larger than the 439,600 jobs in Table 8 because of the wider definition of direct health employment used in this analysis.

Table 23: **Total direct employment in health and social care in the North West**

Health and social care sector	*Sefton*	Liverpool City Region	Greater Manchester Region	Cumbria Lancashire & Cheshire areas	North West Region Headcount	North West Region FTE
NHS Medical	*346.0*	4,184.0	7,073.0	4,254.0	15,511.0	13,848.6
NHS non-medical	*3,450.0*	40,578.0	64,257.0	61,756.0	166,591.0	144,861.7
GPs	*174.0*	1,102.0	1,988.0	2,550.0	5,640.0	5,036.0
GP Practice staff	*467.1*	4,054.0	6,992.0	7,588.0	18,634.0	15,528.0
NHS Dentists	*192.0*	844.0	1,340.0	1,605.0	3,789.0	3,383.0
Dentists practice staff	*189.5*	1,266.0	2,010.0	2,407.0	5,683.0	3,738.8
Ophthalmic	*41.0*	275.0	594.0	659.0	1,528.0	1,364.0
Ophthalmic Practice staff	*53.9*	550.0	1,188.0	1,318.0	3,056.0	2,010.5
Public Health	*193.0*	1,085.0	1,940.0	2,068.0	5,093.0	4,547.0
Medical, dental, nursing & health education	*0*	776.0	767.0	649.0	2,192.0	1,957.0
Private hospitals	*n/a*	n/a	n/a	n/a	5,100.0	4,434.8
Local authority adult social care	*9,400.0*	49,800.0	75,400.0	93,600.0	218,800.0	182,000.0
Voluntary sector	*706.0*	5,736.0	10,260.0	10,933.0	26,929.0	18,583.0
Outsourced FM staff NHS Trusts	*n/a*	n/a	n/a	n/a	5,585.0	4,654.2
Research Centres	*n/a*	n/a	n/a	n/a	2,000.0	1,739.1
Sub total	***15,212.5***	**110,250.0**	**173,809.0**	**189,387.0**	**486,131.0**	**407,685.7**
Local authority residential care	*0*	612.0	1,644.0	3,348.0	5,604.0	4,670.0
Private nursing and residential care	*n/a*	13,189.0	17,255.0	29,623.0	60,067.0	47,978.7
Sub total	***15,212.5***	**13,801.0**	**18,899.0**	**32,971.0**	**65,671.0**	**52,648.7**
Total	***15,212.5***	**124,051.0**	**192,708.0**	**222,358.0**	**551,802.0**	**460,334.4**

Sources: Tables 8-25, Social care includes private and voluntary sector – avoid double counting
(Note: the following multipliers were used in the conversion of FTE to the number of jobs: NHS Medical staff, – 1.12; NHS non-medical staff - 1.15; GP Practice staff, Dentist Practice staff and Ophthalmic Practice staff – 1.52; and Voluntary sector – 1.45, Public Health - 1.12; Local authority social care – 1.30). Local authority residential care data adjusted to FTE using 0.80 ratio, Fig. 2.6, Personal Social Services, HSCIC, 2014.

Indirect employment in the supply chain

Analysis of the local, regional and national share of NHS Trust and local government expenditure is complex. Firstly, identifying and quantifying expenditure on the different types of goods and services requires a disaggregation of expenditure, which is not available in NHS Trust and Department of Health annual reports and accounts. Each type of expenditure supports different levels of employment in their production and supply.

Secondly, differentiating between the production and supply of goods and services is very difficult because national and multinational companies frequently invoice from branch plants or regional offices, but this does not mean that goods were produced in the region. Many companies operate under a variety of trading names making the tracking of production/ supply of goods and services even more complex. A three-stage approach was adopted in this analysis to take account of limited resources.

NHS and local authority social care expenditure on goods and services

The first stage examined the operating expenses of a sample of twelve NHS Trusts to identify expenditure on goods and services. Clinical supplies and drugs were the largest expenditure after employment costs (Table 24).

Table 24: **Operating expenses of a sample of twelve NHS Trusts in the North West**

Operating expense	Total costs (000)	% of operating costs
Services from NHS bodies	52,471	1.8
Purchase of healthcare from non-NHS bodies	14,150	0.5
Clinical supplies including drugs	493,686	17.1
General supplies	57,757	2.0
Consultancy services	11,171	0.4
Establishment	37,971	1.3
Transport	7,109	0.2
Premises	127,009	4.4
Education and training	4,804	0.2
Sub total	806,128	27.9
Staff costs	1,815,528	62.8
Total	**2,888,734**	-

Sources: 12 NHS Hospital Trusts – Southport & Ormskirk Hospital, St Helens and Knowsley Teaching Hospitals, Alder Hey Children's Hospital, Aintree University Hospital, Wirral University Teaching Hospital, Pennine Acute Hospital, The Christie Hospital, Bolton Hospital, Tameside Hospital, Clatterbridge Cancer Centre, Wrightington, Wigan and Leigh, Walton Centre Hospital.

The second stage sought to identify total public spending on goods and services by all health organisations in the region. The Department of Health annual accounts are compiled from the expenditure of 102 NHS Trusts, 147 NHS Foundation Trusts, 5 Special Health Authorities, NHS England (including 211 CCGs), 8 Executive Non Departmental Public Bodies, and 4 other bodies and NHS charities. Again the expenditure is identified for very broad categories.

The North West element of expenditure was calculated using the regions 14.8% share of national health expenditure (Table 4). The expenditure on goods and services by NHS and other publicly funded health organisations and sourced in the North West was £758.8m in 2013-2014 (Table 25).

Table 25: **The North West share of Department of Health expenditure on goods and services**

Expenditure on goods and services	Department of Health Group total 2013 -2014 (000) (£m)	North West share based on 14.8% share health expenditure in 2013-2014 (£m)	Assume average 25% expenditure within North West region
Supplies and services – Clinical	3,898.8	577.0	144.2
Supplies and services – General	1,852.9	274.2	68.5
Prescribing costs	8.015.2	1,186.3	296.6
Pharmaceutical services	2,099.8	310.8	77.7
Transport	388.1	50.0	12.5
Premises	3,303.3	488.9	122.2
Education, training and conferences	418.4	61.9	15.5
Consultancy services	584.7	86.5	21.6
Total	**20,561.2**	**3,035.6**	**758.8**

Source: Department of Health Annual Report and Accounts 2013-2014

Total local authority social care expenditure in the North West in 2013-14 was £1,002.2m, net of funding residents in private and voluntary sector nursing and residential care homes (HSCIC, 2014a). Expenditure on goods and services is estimated to be 25% of total expenditure - £250.0m.

Private and voluntary sector purchasing

The 621 nursing and 1,431 residential care homes in the private and voluntary sector in the North West spent an estimated combined £455.6m on food and other non-staff costs such as energy and other utilities in 2012-2013. This based on the cost of food, capital expenditure on buildings and equipment and other non-staff costs accounting for 3%, 2% and 15% of the £38,000 annual cost per bed for nursing homes and 5%, 18% and 3% respectively of the £27,500 per annum cost per bed in residential care, both based on 90% occupancy (Grant Thornton, 2014). Annual expenditure on goods and services by the 23 private hospitals with 814 beds (Table 17) was estimated to be £81.4m in 2013-2014 (based on a goods and services cost of £100,000 per bed and taking account of no accident and emergency, research and teaching hospital functions). Total health and social care expenditure on goods and services were estimated to be £3,822.6m in 2013-2014 (Table 26).

Table 26: **Expenditure of goods and services by health and social care organisations**

Expenditure on goods and services	**2013-2014 expenditure (£m)**
NHS trusts and organisations	3,035.6
Local authority social care	250.0
Private hospitals	81.4
Private/voluntary nursing and residential care homes	455.6
Total	**3,822.6**

An economic analysis of the £547m 2009-2010 expenditure by the Aneurin Bevan Health Board, Wales concluded that 22% was spent within Wales (Morgan et al, 2010). This study produced an output multiplier of 1.78 and an employment multiplier of 1.82 (Indirect and induced employment), in effect one full-time Health Board employee supported a further 0.82 full-time job in the Welsh economy.

The percentage of local expenditure has been increased from 22% to 25% for the North West analysis to take account of the regions larger pharmaceutical and manufacturing sector, which increases the level of local sourcing. Total expenditure on goods and services by public, private and voluntary health and social care organisations was therefore £955.6m in 2013-2014.

Construction

NHS Trust and PCT capital expenditure totalled £158.2m in 2012-2013, which included £121.7m investment in secondary care premises and £36.5m investment in health centres and GP practices (NHS Strategic Health Authority, 2013). NHS Foundation Trust consolidated expenditure is reported separately. Total capital expenditure for 28 NHS Foundation Trusts in the North West was estimated to be £380.9m in 2013-2014 (Monitor, 2014). This data excludes repairs and maintenance undertaken by NHS Trusts as part of facilities management and estate expenditure (see Tables 44 and 45).

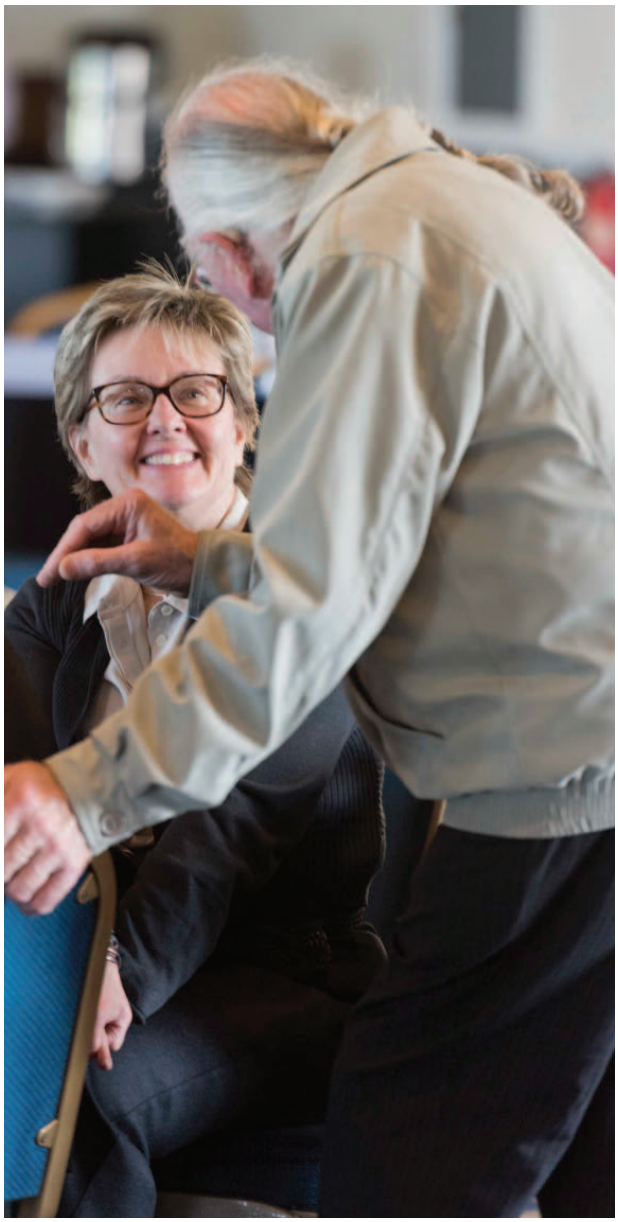
The region has two major PFI hospital contracts under construction (Royal Liverpool and Alder Hey (see Part 5) with a combined capital value of £619.3m with planned construction period of 2.25 years and 3.25 years respectively (HM Treasury, 2014a). This is equivalent to £154.8m per annum for the March 2013 to March 2017 period. Thus the total estimated capital expenditure by NHS Trusts, NHS Foundation Trusts and PFI projects in the North West in 2013-2014 was £693.9m. Using the Scottish Enterprise coefficient of 13.3 jobs/£1m means that NHS capital investment created about 9,230 construction jobs in 2013-2014 (Forbes et al, 2012).

The employment impact of construction is included in Type 1 and 2 multipliers and is thus taken into account in the calculation of indirect and induced employment. Evidence shows that £1m construction output generates a construction output multiplier of £2.09m in economic activity and £2.84m when the induced impact is taken into account (L.E.K. Consulting, 2009).

Large PFI schemes are accounted for separately from NHS capital investment and are, therefore, likely to lead to an underestimation of the employment impact of construction.

The beginning of this section provided the direct and indirect employment figure in the health and social care economy supports additional jobs (induced employment) in the region. Table 27 summaries the

employment data in the preceding tables in FTE, which is required to determine the level of indirect and induced employment.



Indirect and induced employment

The indirect employment created by regional health and social care expenditure on goods and services is calculated using the Scottish Government Input-Output Tables for 2011 (Scottish Government, 2014). Health services have a Type 1 Leontiff employment multiplier of 1.2 and nursing and residential care services a multiplier of 1.5 producing indirect employment of 107,861 FTE (Table 27). The Input-Output Tables require full-time equivalent employment data.

Type 2 Leontiff multipliers are used to calculate the combined indirect and induced employment (including taking account of the effect of demand created by employment in the supply of goods and services). Health services have a combined indirect and induced employment multiplier of 1.5 and nursing and residential care services 1.7 producing induced employment of 132,836 (Table 27).

The total employment impact is 701,031 FTE. The preceding analysis identified a total of 551,802 direct jobs in the North West health and social care economy.

When the indirect and induced employment data are converted to headcount (based on a 1.2 multiplier, the total direct, indirect and induced employment impact of the North West health and social care economy rises to 840,638 jobs.

Table 27: **Total direct, indirect and induced employment in health and social care economy**

	Type 1 Multiplier Indirect impact			
Sector	**FTE**		**Total FTE**	**Total headcount**
Health services	407,686	x 1.2	489,223	
Nursing & residential care	52,649	x 1.5	78,973	
Sub-total	460,335		568,196	
Indirect employment			**107,861**	**129,433**
	Type 2 Multiplier Induced impact			
Health services	407,686	x 1.5	611,529	
Nursing & residential care	52,649	x 1.7	89,503	
Sub-total			701,032	
Induced employment			**132,836**	**159,403**
Direct employment				**551,802**
Total				**840,638**

Source: Input-Output Tables 2011, Scottish Government, 2014. Conversion of FTE to headcount based on a 1.2 multiplier.

In addition, there were 781,972 people providing unpaid care in the North West in 2011, of whom 113,003 carers provided between 20-49 hours per week and 199,476 carers provided over 50 hours per week (Lancashire County Council, 2013).

Profile of the health and social care workforce

Four out of five of the NHS non-medical staff and the social care workforce are women in contrast to 43% of the medical staff and a similar percentage of dentists. Just over half of GPs and opticians are women (Table 28).

Table 28: **Gender of the health and social care workforce**

North West region	Female (%)	Male (%)
NHS Medical staff	43.0	57.0
NHS Non-Medical staff	82.0	18.0
Adult social care workforce	82.0	18.0
General Practitioners	51.0	48.5
Dentists (England)	46.1	53.9
Oppthalmic	51.0	49.0
NHS England	**73.1**	**26.9**

Source: HSCIC, NHS Workforce Statistics, January 2014, Provisional and NHS England Annual Report and Accounts 2013-2014.

26% of the NHS medical staff in the North West is Asian or Asian British and 54% white, which contrast with the non-medical staff where only 3% are Asian or Asian British (Table 29). Both the non-medical and adult social care workforce are predominately white.

Table 29: **Ethnicity of the health and social care workforce**

North West	% White	% Black or Black Asian	% Asian or Asian British	% Mixed	% Chinese	% Any other Ethnic group	% Unknown Ethnicity/ undisclosed
NHS Medical	54	3	26	3	2	4	7
NHS Non-Medical	91	1	3	1	0	1	3
Local authority Adult Social Care	92						
NHS England	**71.1**	**2.8**	**5.1**	**0.9**	**0.4**	**0.3**	**19.2**

Source: HSCIC, NHS Workforce Statistics, January 2014, Provisional and NHS England Annual Report & Accounts 2013-2014.

Only 1% of the North West medical staff report a disability whereas 3% of non-medical do, the latter percentage being aligned with NHS England (Table 30).

Table 30: **Disability in the health and social care workforce**

North West	Disabled	Not Disabled	Unknown/ Not Disclosed
NHS Medical	1	50	49
NHS Non-Medical	3	55	43
NHS England	**2.3**	**51.7**	**46**

Source: HSCIC, NHS Workforce Statistics, January 2014, Provisional and NHS England Annual Report and Accounts 2013-2014.

The following section examines the impact of marketisation and privatisation in the North West health and social care economy.

Part 5 Changing provision: the marketisation and privatisation of health and social care

This section examines the scale of marketisation and privatisation in the North West, the use of PFI, and the commercialisation of voluntary services groups. It quantifies the public costs of these policies and the impact of the increasing role of the private sector in the health and social care economy.

Transformation of health and social care

Transformation has centred on the marketisation and privatisation of public services, with a new emphasis on financialising and personalising services to create new pathways to privatisation. The mutation of privatisation recognised that the NHS and other public services could not be sold off in the same way as state owned corporations. In fact, financialising and personalising services were essential to reconfigure public services to ensure that marketisation and privatisation were permanent and not dependent on outsourcing, which could be reversed by terminating or not renewing contracts. Financialisation, personalisation, marketisation and privatisation are inter-dependent and sequential with each stage contributing to the next (Whitfield, 2012a and 2012b).

Transformation has been underpinned by neoliberal ideology, which has been highly influential in determining the emphasis on competition and markets in both the economy and in public sector reform for the last three decades.

The recession and austerity policies adopted in the wake of the global financial crisis since 2008, allowed transformation to accelerate with further deregulation, commercialisation, a flexible labour market, a pro-business climate through corporate representation on public bodies and government financed market-making activities.

Typology of health and social care marketisation and privatisation

Outsourcing

- Management of NHS hospitals
- Surgery/medical services
- Clinical support services such as Pathology, Radiology, Pharmacy
- Rehabilitation and care services
- Primary care and community services
- NHS Admin/corporate services IT, Finance, HR and recruitment
- FM hard – estates and building maintenance
- FM soft – cleaning, catering, portering, laundry
- Home care and day care services
- Competition advice and procurement
- Personal health and social care budgets

Sale or transfer of public assets

- Transfer of NHS services to social enterprises/ mutuals
- CSU privatisation and other organisations
- Sale of residential care homes

Private finance

- Private Finance Initiative and LIFT infrastructure projects
- Social Impact Bonds
- Increased charges for services

Restructuring and transforming services

- Commercialisation of the voluntary sector

See Whitfield 2012a for a fuller typology of marketisation and privatisation

National context - Outsourcing NHS services

A total of 3,494 contracts were awarded by 182 Clinical Commissioning Groups (CCGs) in England between April 2013 and August 2014. Non-NHS providers secured 45% of contracts awarded since April 2013 (British Medical Journal, 2014). Some £18.3bn worth of NHS contracts had been advertised in 865 contract notices in the 18 months since the Health and Social Care Act came into effect (NHS Support Federation, 2014). The Coalition government revealed the share of the NHS budget to pay private providers increased 58% from £4.14bn to £6.55bn between 2009-10 and 2013-14 (Campbell, 2015).

The private sector won 1,149 contracts (33%), 335 contracts (10%) were awarded to voluntary and social enterprise sector providers, while 100 contracts (2%) were awarded to other providers, such as joint ventures or local authorities. NHS hospitals, community and mental health providers and general practices were awarded 1,910 contracts (55%).

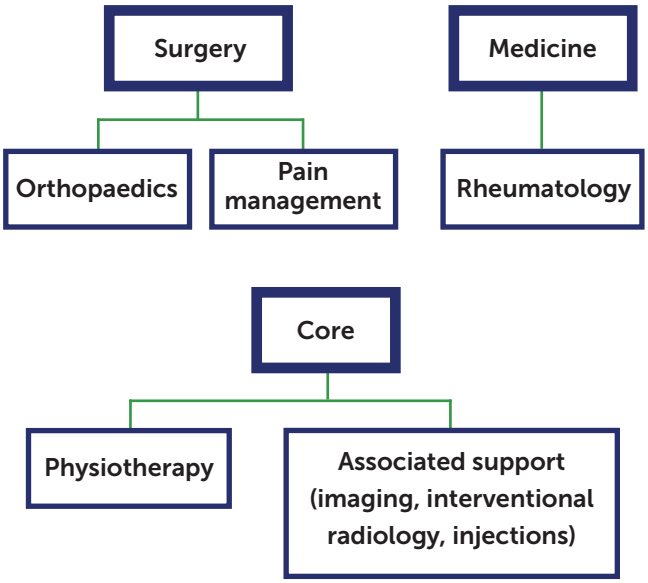
CCGs disclosed the value of only 38% (1,349) of contracts. Of these contracts, the NHS were awarded £8.5bn (85%), voluntary and social enterprise £690m (7%), private companies were awarded £490m (5%), and other contractors were awarded £330m (3%).

Private companies succeeded in winning contracts awarded through a procurement process - 80 (41%), compared to 59 (30%) won by NHS Trusts. Private companies were more successful in winning smaller contracts on an Any Qualified Provider basis for diagnostics, audiology and podiatry services (British Medical Journal, 2014).

Outsourcing core services

NHS outsourcing has extended to large medical contracts inclusive of specialist and support services (Figure 7). For example, a Coastal West Sussex MSK five-year £235m contract was awarded to a BUPA – Central Surrey Health (social enterprise) joint venture in late 2014, but they withdrew from the contract in January 2015 (Health Service Journal, 2015a).

Figure 7: **Services included in Coastal West Sussex CCG Musculoskeletal contract**



Service	MSK services tendered
Orthopaedics	Activity for patients aged 18 and over, excluding trauma and eight weeks post trauma
Rheumatology	All activity (excluding provision to inpatients in hospital for other reasons)
Physiotherapy	Community activity for patients aged over 18
Pain Management	Activity for patients aged over 18
Associated support	Imaging, Interventional radiology injections

The Western Sussex Hospitals NHS Foundation Trust and the NHS Coastal West Sussex CCG commissioned a consultants report that concluded:

- there are potential risks if providers conduct outpatient activity, but do not also provide inpatient services;
- moving some Trust services into the community can achieve benefits, but could have a negative impact on other services remaining in the Trust;
- the negative financial impact over the five-year contract could be £13.4m; *"The cumulative impact of loss of MSK services results in the Trust falling into deficit over the next five years. This position may significantly worsen should some of our sensitivities be realised"* (PricewaterhouseCoopers, 2014).

The contract represented about 10% of the Western Sussex Hospitals NHS Foundation Trust annual income that warned that the contract could destabilise its trauma services.

The potential financial impact on the Trust should have been self-evident to the CCG and the bidders, and a full impact assessment would have provided the evidence. This suggests that the wasted cost of procurement should have been avoided and spent on an in-house 'new model of care' and an innovation and improvement strategy.

More generic lessons include regarding embarking on outsourcing; rigorous options appraisal; full involvement of staff, patient and community organisations; and overstating the private sectors capability to implement innovation, integration and new models of care. The services are likely to remain within the NHS (Health Service Journal, 2015b).

Other examples of large multi-service contracts include the Cambridgeshire and Peterborough CCG's £800m five-year elderly care contract was won by UnitingCare Partnership, a consortium of Cambridgeshire and Peterborough NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust and private contractor Mitie. Ten companies or organisations were originally shortlisted including Virgin Care, United Health, Capita, Serco, Care UK, Circle Health and Interserve together with several NHS Trusts.

The contract includes urgent care for adults aged over 65 including inpatients and A&E services; mental health services for people aged over 65; adult community health services for example, district nursing, rehabilitation and therapy after injury or illness, speech and language therapy, care for patients with complex wounds, support for people with respiratory disease or diabetes; and other health services which support the care of people aged over 65 (Cambridgeshire and Peterborough CCG, 2014).

The £1.22bn cancer care/end of life care contract by Cannock Chase, North Staffordshire, Stoke-on-Trent and Stafford and Surrounds CCGs is another example of complex core service contracts (Campbell, 2014). Circle Health (majority owned by hedge funds) won first the Muskculoskeletal (MSK) contract from Bedfordshire CCG, a five year £120m contract that commenced in April 2014.

The scope and size of these contracts is significant. Equally important, in effect they take a slice of NHS activity from surgery and related services with associated support services into one contract. They often lead to consortium or joint venture bids between NHS and private contractors. They are often framework contracts that allow subcontracting without a tendering process, thus opening up further opportunities for the private sector.

New models of care and integration are commonly justified on the grounds of the scale the project, in particular vertical integration between hospital and community care. This is difficult enough when coordinating NHS and local authority services, more complicated with a purchaser/provider split in the NHS and local government, and more complicated still when market competition requires a procurement process with private companies. A refocus on collaboration, joint working and service level agreements would avoid the substantial transaction costs of procurement and reduce risks.

Outsourcing in North West England

NHS Trusts and CCGs in the North West have outsourced nearly £41m of contracts since April 2013 (Table 31). The Table excludes contracts that were awarded to other NHS Trusts, indicating a larger number of services were subject to competitive tendering. The bulk of the contracts by number and value were awarded to companies located outside of the North West.

Table 31: **NHS Outsourcing in the North West April 2013 - November 2014**

Date	NHS Trust or CCG	Service	Contract award	Value (£)
30/04/2013	Pennine Acute Hospitals NHS Trust	Pathology services: Managed Service for the provision of Blood Gas Analytical Systems	Sysmex UK Ltd	1,683,000
04/05/2013	Countess of Chester Hospital NHS Foundation Trust	Pathology services	bioMérieux UK Ltd	n/a
31/05/2013	Walton Centre NHS Foundation Trust	Diagnostics: Provision of Outpatient EMG/ NCS Service.	Bespoke Healthcare Ltd	500,000
02/07/2013	Central Manchester University Hospitals NHS Foundation Trust	Provision of intermediate. care services	Bupa Care Services Ltd	2,282,280
11/10/2013	University Hospital of South Manchester NHS Foundation Trust	Diagnostics (Imaging)	Radiology Reporting Online, London	939,000
20/11/2013	Blackpool Teaching Hospitals NHS Foundation Trust	Pharmacy	Lloyds Pharmacy Limited	1,920,695
07/01/2014	NHS Blackpool PCT on behalf of Greater Manchester PCT's	Patient Transport	Arriva Passenger Services Limited	1,800,000
12/02/2014	Southport & Formby Clinical Commissioning Group	Residential nursing care services. Hospice at Home Service	Queenscourt Hospice, Woodlands Hospice Charitable Trust	1,200,000
01/06/2014	Greater Preston CCG	Physiotherapy	Chorley Medics Ltd, Injury Care Clinics, Hampshire & Healthshare Ltd, Kent	No guaranteed income
25/06/2014	Trafford CCG	Home care	Air Liquide (Home Care) Ltd, Droitwich	599,940
04/07/2014	East Lancashire CCG	Minor Injuries Service	Coastal Health Care Ltd, Blackpool	1,400,000
04/07/2014	North Salford CCG	Care Home Services Unit	Swinton Hall Nursing Home	1,600,000
13/09/2014	Pennine Acute Hospitals NHS Trust	Radiology Reporting	P & H Care Ltd (trading Home name Atlas Diagnostics) Altrincham	600,000
24/09/2014	Lancashire Teaching Hospitals NHS Foundation Trust	Diagnostics	Phadia Ltd, Altrincham	663,890
24/09/2014	Pennine Acute Hospitals NHS Trust	Orthotics	Crispin Orthotics Ltd, Leeds	840,345
25/09/2014	Southport and Ormskirk Hospitals NHS Trust	Nursing staff to cover vacancies	Service Care Solutions, Preston: Castlerock Recruitment Group, St Helens	1,880,000
25/09/2014	Pennine Acute Hospitals NHS Trust	Pharmacy	Lloyds Pharmacy Limited	1,876,000
26/09/2014	Countess of Chester Hospital NHS Foundation Trust	Diagnostics	Genmed Ltd, Hayes	2,300,000
01/10/2014	Lancashire Teaching Hospitals NHS Foundation Trust Sussex	Diagnostics (Pathology)	Roche Diagnostics, Burgess Hill, West	12,000,000
02/10/2014	Bolton NHS Foundation Trust	Diagnostics (Ultrasound)	Independent Vascular	n/a
01/11/2014	Greater Preston CCG	Muskculoskeletal triage, assessment and treatment service	Services Limited, Bolton Virgin Care Services Ltd	6,900,000
Total				**40,985,150**

Source: NHS Support Federation, Contract Database, 2015.

At least a further six contracts valued at £51.9m are currently in procurement:

- Wirral CCG – Primary Care Mental Services, £7.7m to £9.5m.
- NHS England (Cheshire, Warrington and Wirral Area Team), Primary Care Oral Surgery, £5.0m
- Bury CCG and North West CCG Associates, Specialist Mental Health Services for Military Veterans, £2.4m.
- NHS Shared Business Services on behalf of Blackpool CCG, five non-emergency patient transport services contracts in the North West, no value but current aggregate of current contracts is £35m.
- East Lancashire NHS Trust, Royal Blackburn Hospital, Microbiology Managed Service (no contract value stated).
- Lancashire Child Health Information System (no contract value stated).

Some contracts could of course be awarded to NHS Trusts or other public bodies.

Clinical support services such as diagnostics, pathology and radiology accounted for the largest number and value of contracts. Sefton accounted for £3.1m of the contracts and Liverpool City Region £3.6m in contrast to the £27.0m in Cumbria, Lancashire and Cheshire and £10.5m in the Greater Manchester City Region. Most are three-year contracts.

Outsourcing facilities management

NHS Trusts in the North West had outsourced £268.6m of facilities management (FM) services by 2013—14 (Health and Social Care Information Centre, 2014). Seven Trusts with operational PFI contracts outsourced an average 46.4% of FM services, a total of £103.8m. The thirty-four non-PFI trusts outsourced an average 28.6% of facility management services with average value of £3.0m (see Table 45, Appendix 2).

The current value of outsourcing of NHS facilities management and NHS services is £309.6m and this does not take account of contracts awarded prior to April 2013 or local authority contracts in the North West.

The data includes hard FM (estates – repairs, maintenance, mechanical and engineering services) and soft FM (hotel services such as cleaning, catering, portering, reception, security, grounds maintenance, waste management, car park management), inclusive of equipment maintenance, repairs, management and manpower resources contracted out to non-NHS independent sector companies and inclusive of PFI contracts. Services provided by another NHS organisation under service level agreement are classified as non-contracted out, but relevant costs are included in the total cost for the services.

Other NHS contracts in the North West

Eight North Mersey NHS Trusts awarded a £27m seven-year payroll, human resource and recruitment contract to Capita plc in 2012 (Capita, 2012). The projected savings were less than 40% of those originally planned and were minimal for some trusts (Liverpool Echo, 2011). The Trusts complained of over- and under-payment of staff and Capita breaches of data protection laws in releasing employee information. By summer 2014 five trusts (Royal Liverpool and Broadgreen University Hospitals, Walton Centre Foundation Trust, Mersey Care Trust, Liverpool Community Health Trust and Aintree University Hospital Foundation Trust) had brought services in-house or moved to another provider. Alder Hey Children's Hospital and Liverpool Heart and Chest Hospital followed in autumn 2014. Southport and Ormskirk Hospitals NHS Trust was originally involved in the project, but withdrew during the procurement process (Campaign4Change, 2014).

It is vital that lessons are learnt from this failed project and the full costs identified. This is particularly important since the £9.8bn failure of the NHS national IT programme (House of Commons Public Accounts Committee, 2013). This figure increased when the government lost a £700m claim plus £50m legal costs against one of the contractors, Fujitsu, in 2014 (Cameron, 2014). The government's own legal costs were already £31.5m a year earlier.

CCG 'Any Qualified Provider' contracts

CCGs took over responsibility for contracts awarded by their predecessor Primary Care Trusts, but they have also commenced procurement for additional services (Table 32). Some services are contracted to non-NHS providers who are licensed to compete for NHS patients under the Any Qualified Provider (AQP) programme. The Department of Health expects each CCG to choose to undertake three out of eight specified service lines for the implementation of the programme, designed supposedly to 'increase patient choice'. In effect it widens the role of the private sector in the NHS.

Table 32: **CCG contracts to non-NHS providers under Any Qualified Provider scheme**

CCGs	Audiology	Diagnostics	Elective surgery	Minor oral surgery	Podiatry	Musculo skeletal	Derma-tology	Urology services
South Sefton	■				■	■		
Southport and Formby	■				■	■		
Liverpool City Region								
Liverpool	■				■	■		
St Helens	■				■	■		
Knowsley	■				■	■		
Halton	■				■	■		
Wirral	■	■	■		■	■		
Greater Manchester CR								
Bolton	■	■	■	■	■			
Bury	■	■	■	■	■			
Heywood, Middleton & Rochdale	■	■	■		■			
North Manchester								
South Manchester								
Oldham	■	■	■		■			
Salford	■	■	■	■	■			
Stockport	■	■	■		■			
Tameside	■	■	■		■			
Trafford	■	■	■		■			
Wigan	■	■	■		■			
Cumbria, Lancashire & Cheshire areas								
Cumbria		■	■				■	■
Blackpool	■	■					■	
Lancashire North	■		■				■	
Fylde & Wyre	■		■					
West Lancashire	■			■				
East Lancashire	■			■				
Blackburn with Darwen	■	■		■				
Warrington	■		■					■
West Cheshire	■	■	■					
Eastern Cheshire	■		■					

Source: NHS Support Federation database. Wirral CCG also contracted Gynaecology, Glaucoma, Cystoscopy, Mental Health, Domiciliary Care and Joint and Soft Tissue Community services: Stockport CCG – Minor Eye Conditions service: Oldham CCG – Minor Hand Surgery: Liverpool CCG – Homeopathy: Eastern Cheshire CCG – Vasectomy service: East Lancashire CCG – Lymphoedema service: Cumbria CCG – Stop Smoking service

In autumn 2012 the Department of Health increased the range of services to 39 under the AQP programme. By early 2013, nearly ninety providers had been licenced, comprising 26 NHS organisations, 38 private firms, 18 charities and four social enterprises (GPonline, 2012).

Fifteen North West CCGs adhered to the Department of Health's pressure to select a minimum of three Any Qualified Provider (AQP) services and selected no additional services. However, three Greater Manchester CCGs contracted five AQP services and six contracted four services. In the North West, the four most common contracts are audiology, diagnostics, elective surgery and podiatry (Table 31). There are several spatial concentrations, for example, five of the seven Liverpool CCGs have musculoskeletal contracts; podiatry contracts are concentrated in Liverpool and Greater Manchester; diagnostic and elective surgery concentrated in Greater Manchester.

Virgin Care in the North West

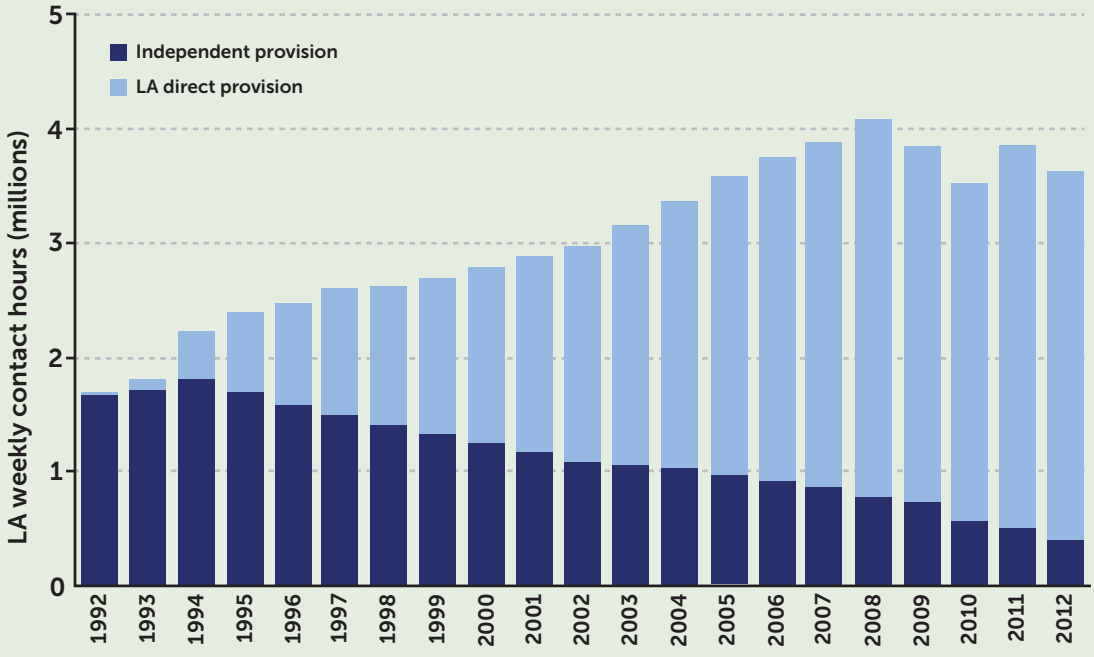
Virgin Care is an example of how a private health firm can establish a regional foothold by using the NHS competition regime to win contracts. It has won so far in the North West and will no doubt for bidding for more:

- 3 Dermatology services in Sefton (plus minor surgery service), Wirral and Oldham
- 2 Musculoskeletal services in Preston and Chorley
- 4 sexual health centres, Oldham
- 1 Urgent Care Centre, Lancaster
- Urology and ophthalmology services, Macclesfield
- Audiology; Ear, Nose and throat; orthopaedic; rheumatology; physiotherapy; podiatry, ophthalmology, nerve conduction studies; flexible sigmoidoscopy; and Improving Access to Psychological Therapies (IATP) in Wirral.

Outsourcing local authority social care

The switch to independent sector provision of social care commenced in 1994 with Conservative 'care in the community' and accelerated as the demand for social care increased in parallel with local authorities increasingly outsourcing social care (Figure 8). The share of direct local authority employment continued to decline even when the total contact hours declined following the start of the financial crisis in 2008. The graph below shows the decline in direct local social care employment to 2012, but continued public spending cuts and outsourcing is likely to have continued the downward trend.

Figure 8: **The switch from direct provision to private and voluntary sector provision**



Source: L&B Domiciliary Care 2013

NHS and local authority services transferred to social enterprises

The transfer of NHS or local authority services to social enterprises and mutuals results in staff being employed by these companies and are no longer public employees. It is privatisation and does not constitute economic growth because it is transfer between sectors in the economy. Transfers de-facto helps to create or widen the market for health and social care services. It is significant that this model is advocated for the public sector, but not for private sector manufacturing and service companies supplying the health and social economy.

NHS Trusts in the North West have transferred services to seven social enterprises since 2009 Table 33). They account for £18.6m annual turnover and 643 staff.

Table 33: **NHS and local authority services transferred to social enterprises**

Local Authority/City Region	Local authority or City Region	Services	No of jobs	Annual turnover £m
Future Directions Community Interest Company (CIC) (2012)	Oldham	Social care learning disabilities, mental health & complex needs	453	12.6
Spiral Health CIC (2012)	Blackpool	2 rehab units – 61 beds	53	3.1
Social AdVentures	Salford	Healthy Living Centre	n/a	0.5
Six Degrees Social Enterprise CIC (2011)	Salford	Mental health	25	1.2
Bolton Community Practice CIC (2011)	Bolton	4 GP surgeries	45	n/a
Salvere Social Enterprise CIC (2010)	Lancashire	Care services & staff for personal budget holders	32	0.9
Sunshine Care (Rochdale) CIC (2009)	Rochdale	Home care	35	0.3
Total			**643**	**18.6**

Sources: Company websites and annual returns to Companies House.

The Future Directions Community Interest Community (CIC was established by Calderstone Partnership NHS Foundation Trust. The Trust transferred services to the CIC in 2013. However, within months the CIC Board notified the Trust that many services were 'uneconomic'. The CIC was unsuccessful in retendering of the services. All but one of the CICs services in Trafford was awarded to new contractors in October together with three services funded by Bury MBC in March 2014. The CIC succeeded in winning "new profitable business" in Halton and new services developed in the North West (Future Directions, 2014).

The CICs 2013-2014 accounts revealed *"Contract subsidies from Calderstone Partnership NHS Foundation Trust and other income"* was £459,685 following £228,480 the previous financial period (ibid). It also has a £600,000 loan from the Trust chargeable on a monthlybasis and payable quarterly. The 2013-2014 accounts also include a £225,050 settlement cost for 99 Employment Tribunal cases and £44,000 agreed redundancy costs.

The Department for Communities and Local Government issued a demand notice in late November 2014 to recover £1.4m of public money from Social Enterprise North West (SENW). The audit of a European Regional Development Grant to run a business advisory service in Liverpool found *"...serious breaches in the projects accounts"* (DCLG, 2014b). SENW ceased trading on 31 December 2014.

Three North West NHS trusts, Cheshire and Wirral Partnerships NHS Foundation Trust, Liverpool Heart and Chest Hospital NHS Foundation Trusts and Tameside Hospital NHS Foundation Trust, are included in nine Pathfinder Trusts to become mutual/social enterprises. The Cabinet Office appointed consultants to each Trust for three months at a cost of up to £120,000 per trust. However, the Norfolk and Norwich University Foundation Trust and the Norfolk and Suffolk Foundation Trust both withdrew from the programme in early 2015. Michael Scott, chief executive of the Norfolk and Suffolk Trust, said: *"There has been a level of misunderstanding about the project. We can see that this has led to concern among our staff about a risk of 'privatisation of the NHS'"* (BBC News, 2015).

Private finance in the North West

The capital value of Private Finance Initiative hospital project in the North West more than doubled from £765m in 2003 to £1,909m by 2014 (see Table 37). The region has 79 local health centres with a total capital value of nearly £600m through the NHS Local Improvement Finance Trust programme (Table 34).

Table 34: **Major hospital PFI projects in North West**

PFI Hospital projects	Location	Capital value £m	Unitary charge	Financial close	No of years	Current private equity ownership
Alder Hey Children's NHS Foundation Trust	Liverpool	189.9	502.0	21/03/2013	30	John Laing (40%), Laing O'Rourke (40%) & Interserve (20%)
Royal Liverpool & Broadgreen University Hospitals NHS Trust	Liverpool	329.4	708.9	13/12/2013	30	Carillion (50%) and Aberdeen Asset Managment (50%)
St Helens & Knowsley Teaching Hospitals (NHS) Trust	Whiston Hospital	338.0	3,797.0	01/06/2006	42	Innisfree (80%) & Taylor Woodrow (20%)
Liverpool City Region		**857.3**	**5,007.9**			
Central Manchester University Hospitals NHS Foundation Trust	Manchester	512.0	3,291.0	14/12/2004	38	Lend Lease (50%), HICL (25%), Sodexo (25%)
Salford Royal NHS Foundation Trust	Salford	136.0	715.0	05/09/2007	34	HICL (100%)
Tameside Hospital NHS Foundation Trust	Tameside	112.4	441.0	18/09/2007	33	HICL (100%)
University Hospital of South Manchester NHS Foundation Trust	Wythenshawe Manchester	85.0	1,004.0	08/06/1998	33	Semperian (50%), Sodexo (25%) & Innisfree (25%)
Manchester City Region		**845.4**	**5,451.0**			
East Lancashire Hospitals NHS Trust	Royal Blackburn Hospital	109.6	796.0	09/07/2003	36	HICL (100%)
East Lancashire Hospitals NHS Trust	Burnley General Hospital	30.1	169.0	13/10/2003	35	Catalyst Healthcare (Lend Lease & Aberdeen Asset Management) (100%)
North Cumbria University Hospitals NHS Trust	Carlisle	66.7	654.0	03/11/1997	30	Dalmore Capital (75%) & Interserve (25%)
Rest of North West		206.4	1,619.0			
Total		**1,909.1**	**12,077.9**			

Source: HM Treasury PFI Current Projects List to March 2014.

High cost and affordability - PFI unitary payments

Unitary payments cover the payment of capital costs and financing costs plus payment for facilities management services provided over the contract period. The facilities management services would have to be provided, irrespective of the structure of the contract and are therefore not 'PFI debt' (Table 35). The emaining unitary payments for PFI projects total £10,686.9m. The cost of services accounts for an average 40% of unitary payments, which would be incurred by the trusts irrespective of a PFI project and, hence, are not technically the same debt as availability payments that make up the rest of the unitary payment.

The private sector is only partly funding the Royal Liverpool PFI project. The PFI element is £211.9m with the Department of Health providing £100m of Public Dividend Capital and the Royal Liverpool Trust contributing £24.0m plus £94m of the capital investment (Royal Liverpool and Broadgreen University Hospitals Trust, 2014).

Table 35: **NHS Trust PFI unitary payments due in 2014-2015 to end of contract**

NHS Trust	PFI unitary payments due (£m)	Contract concludes
Alder Hey Children's NHS Foundation Trust	485	2045-2046
Royal Liverpool & Broadgreen University Hospitals NHS Trust	708.9	2046-2047
St Helens and Knowsley Teaching Hospitals NHS Trust	3,609	2047-2048
Central Manchester University Hospitals NHS Foundation Trust	2,878	2042-2043
Salford Royal NHS Foundation Trust	665	2042-2043
Tameside Hospital NHS Foundation Trust	404	2041-2042
University Hospital of South Manchester NHS Foundation Trust	673	2033-2034
North Cumbria University Hospitals NHS Trust	431	2029-2030
East Lancashire Hospitals NHS Trust – Blackburn	686	2041-2042
East Lancashire Hospitals NHS Trust - Burnley	147	2040-2041
Total	**10,686.9**	

Source: HM Treasury PFI current projects database March 2013 and March 2014.

Sale of equity in PFI healthcare projects in the North West

Twenty-three equity transactions took place in the North West PFI healthcare projects between 2005-2014, including the eight major PFI hospital projects, a majority involved the transfer of equity ownership to offshore infrastructure funds in Luxembourg, Jersey and Guernsey – see Table 47 in Appendix 2 (Whitfield, 2012c).

The private sector sells PFI equity to extract profit, reduce risks and to reduce debt to invest in further PPP projects. A few companies have transferred PPP equity to the company's pension fund as alternative to cash payment. Many have sold equity in projects in order to maintain a flow of asset transfers to listed infrastructure funds, such as HICL, John Laing Infrastructure Fund and Bilfinger Berger Global infrastructure. There is also evidence that equity has been triggered to ramp up value of infrastructure assets and to try to support a company's share price in a financial crisis.

Equity in 716 PFI projects (including multiple transactions in some projects) was sold in 281 UK transactions worth £5.8bn since 1998. Health PFI projects accounted for 30% PPP equity sales between 1998-2012 (European Services Strategy Unit, 2012 and Whitfield, 2012c).

The average annual return on the sale of equity in UK PPP project companies was 29% between 1998-2012 – twice the 12%-15% rate of return in PPP business cases at financial close of projects. PPP equity was sold an average of six years after the financial close of the project. The annual return for infrastructure investment is significantly higher than the annual return for shares, bonds and property investment.

Ownership and control of PFI projects matters. The sale of PPP equity provides new opportunities for profiteering, can invalidate value for money, increases offshore tax avoidance, erodes democratic accountability, increases secrecy and trading of publicly financed assets with significant negative consequences for the future of public services and the welfare state.

Offshore infrastructure funds now account for over 75.0% of PPP equity transactions. They have grown rapidly, building portfolios of public assets with equity in 315 UK PPP projects. Five funds have 50%-100% equity ownership of 115 projects. Tax avoidance by infrastructure funds results in a significant annual loss of tax revenue.

LIFT primary care facilities

Local Improvement Finance Trusts (LIFT) is a national public-private programme aimed at improving primary health facilities. They are, in effect, small PFI projects in which the private designs, builds, finances and operate on 25-30 year contracts.

Community Health Partnerships (CHP) is responsible for the overall management of over 300 buildings in England. It has a 40% shareholding in each of the 49 LIFT companies in England. Seventy-nine projects have been completed in the North West with at a total capital cost of nearly £600m (Table 36).

Table 36: **Local Improvement Finance Trust (LIFT) projects in North West**

LIFT Company	No of health centres	Capital value £m	Principle private sector shareholder
Liverpool and Sefton Health Partnership	14	80.7	gbpartnerships (LIFT developer)
Halton, St Helens, Knowsley & Warrington - Renova Developments Limited	18	115.3	Meridiam Infrastructure Group Limited (Meridiam Infrastructure Partners, Luxembourg)
Manchester, Salford and Trafford (MaST LIFT Co Ltd)	12	72.3	Equitix Limited
Bolton, Rochdale, Heywood & Middleton - BRAHM LIFT Limited	6	68.6	Eric Wright Group Limited
Bury, Tameside & Glossop Community Solutions Limited	4	34.9	Equitix Limited
Community 1st Oldham Limited	6	60.1	Equity Solutions Limited
Wigan – Foundations for Life Limited	7	56.4	Eric Wright Group Limited
East Lancashire Building Partnership	9	86.9	Eric Wright Group Limited
eLIFT Cumbria Limited	3	20.3	Express LIFT Investments Limited
Total	**79**	**595.5**	

Source: Community Health Partnerships, 2015.

The Blackpool Primary Care Whitegate Centre was a LIFT project, but was acquired by HICL Infrastructure from the Eric Wright Group in 2012 and is no longer classified as a LIFT project (see Table 46 in Appendix 2).

New private finance - social impact bonds in health and social care

Social impact bonds are similar to PFI projects in that projects are initially financed by private and social investors; a special purpose company is set up for the project which selects a contractor to deliver the service; consultants are involved in setting up project and evaluating performance; investors are usually guaranteed an annual return of between 7% - 13%; but the project is ultimately financed by taxpayers. The growth of support for social impact bonds and a social investment market is an example of how neoliberal policies create new private markets to financialise and privatise public services for a new class of investors, backed by global capital (National Union of Public and General Employees, 2014).

Most importantly, social impact bonds result in the privatisation of policy making, innovation, finance, contract management, service provision and the evaluation of performance. The concept is flawed because it is dependent on comparison with a 'business as usual' public service option. The difficulty in identifying and apportioning outcomes is often not recognised.

Three social impact bond projects are operational in the North West – a children in care project (Manchester City Council) and the North West England and Greater Merseyside NEET (Not in Employment, Education or Training) projects. The social impact bonds will fund interventions to work with around 2,500 14-15 year olds who are disadvantaged or at risk of disadvantage to help them participate and succeed in education or training (Cabinet Office, 2014).

Social impact bonds are also promoted in health care:

- Preventative health care interventions such as those for asthma and diabetes to reduce A&E admissions (Fresno, California)
- Home based services designed to keep elderly out of residential/nursing homes
- Reduce high rate of premature births (South Carolina)
- Reduce teenage pregnancy (Washington DC)
- Reduce substance abuse
- Expert patients programme (UK)
- Development Impact Bonds in HIV and TB prevention in Africa

The first social impact bond in the NHS was launched by the Newcastle West CCG in March 2015 with £1.65m funding from Bridge Ventures, £2m from the Big Lottery Fund and £1m from the Cabinet Office (Health Service Journal, 2015c). The seven-year Ways to Wellness project will help patients manage long term conditions and will be delivered by four voluntary sector organisations.

Social investment projects financialise and commercialise selected services to the poor and most vulnerable in society and legitimate profiteering from their needs with a relatively high annual rate of return for investors. Although much is made of attracting 'social investors', banks such as JP Morgan and other promoters of Social Impact Bonds make the case that projects will be attractive to mainstream private investors.

Social Impact Bonds create a new market for financial intermediaries, bond issuers, contractors and consultants/auditors syphoning off resources from service delivery; they introduce profiteering into services for those most in need, such as troubled families and prisoners awaiting release; a payment mechanism that compares performance with existing rather than improved public services, which could lead to gaming by contractors concentrating on the 'easier' users to maximise 'success' (Whitfield, 2012a).

Commercialisation of voluntary services groups

Community and voluntary organisations have traditionally had a vital role in providing care, support, advice and advocacy in the North West region and nationally. Many have been co-opted by the government and private sector into the marketisation and privatisation agenda. The loss of grants, public spending cuts and the burden of procurement and contracting has led to reduced services, closures and job losses.

The re-designation of voluntary organisations as the 'third sector' with a wider responsibility to deliver public services was a consequence of the acceptance of neoliberal ideology, which led more voluntary organisations into commercialisation and competition. It also led to the silencing of dissent (National Coalition for Independent Action, 2015).

It has not been within the remit of this report to examine the impact of these and other findings of the Inquiry into the Future of Voluntary Services in respect to the health and social care economy in the North West

Public cost of marketisation and privatisation

Most outsourcing and privatisation decisions are made solely on the financial effect on a particular budget and justified by a belief in the value of competition. The full transaction costs are rarely quantified, let alone taken into account in the award of contracts, and significant other public costs are regularly ignored. Nor are other public sector costs taken into account such as the economic, social and environmental impact, the effect on staff terms and conditions, or the cost of making and supporting markets. The knock-on effect on the local economy, other public sector budgets and public policies is conveniently regarded as outside the responsibility of the contracting body.

Cost of outsourcing and privatisation: The average cost of undertaking a contract transaction £5m per organisation:

"The average cost of undertaking a transaction is £5m per organisation, which includes due diligence fees, legal fees, interim staffing, project management and other costs. These fees are often incurred by both the acquiring organisation and the vendor. This is money that could be better spent on patient care; reducing the costs whilst maintaining the integrity of the process would achieve better value for money and deliver better care for patients" (The Dalton Review, 2014).

The cost of monitoring is recommended to be between 1% - 3% of the contract value and up to 7% for complex ICT contracts (Audit Commission, 2008).

Cost of transferring services: Support for the creation of social enterprises and mutuals by Labour and Coalition governments is over £200m to date. This excludes the cost to NHS Trusts and local authorities. Support to voluntary organisations to increase capacity to bid for contracts is £220m (Whitfield, 2012a) and the annual cost of support for community rights to challenge and bid is £37.5m (Whitfield, 2012b).

Cost of private finance: In 2012 the government was forced to allocate a £1.5bn fund to bail out NHS Trusts nationally that were in financial crisis, primarily caused by the excessive cost of PFI projects. Seven trusts were identified including St Helens and Knowsley Teaching Hospitals NHS Trust and the North Cumbria University Hospitals NHS Trust. By March 2014 some twenty NHS Trusts bid for £376m for 2013-2014, including University Hospital of South Manchester Foundation Trust which sought a £25m 'smoothing loan' to mitigate peaks in its PFI payment schedule (Local Government Chronicle, 2014). The cost of the bailouts combined with a rate of return from PFI secondary market equity transaction twice the average return in PFI business cases, invalidates value for money and public sector comparators (Whitfield, 2012c).

Cost of regulation: The combined cost of the three regulatory bodies was £298.2m in 2013-2014. Monitor, the regulator of NHS Foundation Trusts, net operational costs were £64.0m (Monitor, 2014); the NHS Trust Development Authority, regulator of NHS Trusts, costs were £39.6m (NHS Trust Development Authority, 2014); and the Care Quality Commission's operational costs were £194.6m. The CQC technically reduced their operational costs by collecting £101.2m in fees and charges, but these were a cost to NHS Trusts, local authorities, voluntary organisation and private companies (Care Quality Commission, 2014).

Cost of indirect public subsidy: Health and social care accounts for £1.2bn of the £6.5bn annual expenditure on Working Tax Credit, an income-tested refundable tax credit depending on family composition, health, number of hours worked and age of claimant – see Part 8. It is a subsidy for low pay. The private sector is accountable for about £900m of the annual health and care WTC expenditure.

Cost of wasted bids and terminations: 'Fixed priced contracts' and 'guaranteed savings' are part of procurement jargon, but the financial reality is very different. The Department of Health paid £194m between 2007-2008 and 2013-2014 on wasted bid costs, termination and compensation costs to private health and IT companies including Netcare, Care UK, Atos Origin and Clinicenta (Department of Health, 2009, 2010, 2011, 2012, 2013 and 2014). The costs in Table 37 do not take account of the costs borne by NHS Trusts and local authorities over the same period. There is insufficient information to identity the full North West costs.

Table 37: **Department of Health contract losses**

Year	Contract	Wasted bid, termination costs & other costs (£m)
2007-2008	North West and South West Diagnostics ISTC contracts terminated plus West Midlands ISTC terminated.	12.5
	Wasted bid and cancellation costs in other ISTC contracts	6.7
2008-2009	Additional cost of West Midland ISTC termination	17.0
	Further ISTC cancellation or termination costs	14.7
2009-2010	Cumbria/Lancashire and other cancelled or re-scoped ISTC contracts	6.2
2010-2011	Cancellation North London ISTC	8.0
	NHS Gateway early termination of contract	1.6
	Social Enterprise Investment Fund Drug & Alcohol Treatment Centre part write-off of loan	0.6
2011-2012	Renegotiation of Computer Sciences Corporation (CSC) contract for North, Midlands & East	8.8
	De-commitment to CSC – NHS no longer obliged to procure CSC product	100.0
2012-2013	Homerton University Hospital contract with BT	1.0
2013-2014	Early termination Surgicenta ISTC, Stevenage	12.2
	Service charges fro de-commissioned CSC sites	4.7
Total		**194.0**

Sources: Department of Health Resource Accounts 2007-2008; Annual Report and Accounts for 2008-2009, 2009-2010, 2010-2011, 2011-2012, 2012-2013, 2013-2014

Increased administration costs: The NHS *"...has traditionally scored highly on account of its low cost of administration, which until the 1980s amounted to about 5% of health-service expenditure. After 1981 administrative costs soared; in 1997 they stood at about 12%" By 2005 they were estimated to be "...around 13.5% of overall NHS expenditure"* according to a study by University of York (House of Commons Health Committee, 2010). Taking account of changes in the definition and reclassification of management costs it is estimated that *"...at least £5 billion of the NHS's recurrent i.e. continuing, year-on-year running costs relate to the market"* (Paton, 2014).

Cost of management consultants: The cost of management consultants engaged by the Department of Health, Primary Care Trusts, Strategic Health Authorities and NHS trusts was £2.3bn between 2009/10 and 2013/14. Significantly, the annual cost of consultants soared to £607.2m and £584.7m in the last two financial years covering the latest reorganisation (Department of Health, 2010, 2012, 2012, 2013, 2014).

Cost of reorganisation: The abolition of Primary Care Trusts and the establishment of Clinical Commissioning Groups resulted in the Department of Health recording an ''asset impairment" of £48.6m. NHS England had an asset impairment of £120.2m "...for which ownership or usage cannot be proven" (Department of Health, 2014). But the full cost of the 2010-2013 reorganisation, originally estimated by the Coalition government to be £1.4bn are now estimated to be at least £3bn (Paton, 2014). The 2001 reforms are also estimated to have cost £3bn (ibid).

The national costs total nearly £7.5bn per annum or £1.1bn in the North West when the annual costs are added to other costs, which are spread over a five-year period. The total cost is inclusive of a £1bn reduction to take account of potential double counting.

Outsourcing savings; On like-for-like provision outsourcing savings are regularly exaggerated and have historically been between 6.5% - 8.3% in the UK (Whitfield, 2012a).

Increasing corporate role in the North West health and social care economy

Six important trends are evident that reflect the

continuing entry of private companies and financial institutions into the provision of health and social care.

Firstly, over two thirds of the outsourcing contracts by value awarded to the private sector in the North West between April 2013 and February 2014 were awarded to national or international companies. Social care has been outsourced to a variety of local, regional and national companies although it not been possible to provide an analysis of their market share.

Secondly, the equity in three PFI projects – Salford, Tameside and Blackburn – is fully owned by HICL Infrastructure Fund offshore in Guernsey whilst the PFI equity in Burnley hospital is 100% owned by Catalyst Investment Holdings in Jersey. In addition, PFI equity in the Central and South Manchester hospitals is HICL and Semperian PPP Investment in Jersey. The increasing concentration of PFI equity ownership offshore tax havens is certain to have longer-term implications for NHS Trusts (Whitfield, 2012c).

Thirdly, new forms of private finance in health and social care, such as social impact bonds, are likely to be funded by global banks alongside local and/or national 'social investors'. This will inevitably open new opportunities for private capital to fund other health projects.

Fourthly, four private hospital companies operate 18 private hospitals in the North West with 85% of private beds in the region (see Table 16). Three are owned by foreign companies – Ramsey (Australia), BMI (South Africa – principle shareholders are Netcare 53.7%, Apax Partners 32.1% and London and Regional Properties 7.5%), and HCA International has a private patient partnership at the Christie Clinic with The Christie NHS Foundation Trust in Manchester. It also operates a new surgical and diagnostic centre in Wilmslow, Manchester.

The four largest care home companies, Four Seasons Health Care, BUPA Care Homes plc, Barchester Healthcare Ltd and HC-One Ltd operate respectively 32, 37, 18 and 40 care homes in the region.

Fifthly, there are several major pharmaceutical companies in the North West, such as GlaxoSmithKline, Novartis, Sanofi Aventis, Eli Lilly, Bristol-Myers Squibb and AstraZeneca. The latter is moving its research and development from Alderley Park, Cheshire to Cambridge in 2016, but will retain its Macclesfield and Speke, Liverpool manufacturing plants.

Finally, the increasing presence of private companies in the health and social care economy leads to 'market making' activities by the state in addition to those associated with procurement processes. It also results in various forms of corporate welfare, such as tax relief, grants, subsidies, guarantees and concessions together with an increasing role for business in public policy making in health and social care (Whitfield, 2012a).

The US and EU are currently negotiating a Transatlantic Trade and Investment Partnership (TTIP), which (together with negotiations on other agreements - Trade in Services Agreement (TISA) and CETA, the Canada European Comprehensive Economic and Trade Agreement), involve the EU, North America and other countries seeking agreement to liberalise trade in services. The free trade agreements are intended to align regulations, cut tariffs, deregulate, increase marketisation and privatisation of public services. TISA involves 23 members of the World Trade Organisation, including the EU and USA, with ten negotiating rounds completed with more planned.

A draft schedule of commitments and reservations appears to give the EU the right to adopt and maintain any measure with regard too all publicly funded health and social services (European Union, undated). However, the expected TTIP Investor-State Dispute Settlement provisions could potentially enable US investors in current or future privatised NHS services to sue the government if they sought to bring them back into public ownership or provision (Corporate Europe Observatory, 2015). A Health Impact Assessment of the Trans-Pacific Partnership, currently being negotiated between Pacific Rim countries including Australia, US, Japan and Canada, concluded it could increase the cost of medicines, limit the ability of government to regulate and restrict tobacco, alcohol and food labelling policies (Hirono et al, 2015). Heath outcomes were primarily increased hospitalisations, mortality and higher use of emergency services.

Impact on health and social care economy

The Health and Social Care Economy in the North West (2003) report cited the following consequences of marketisation and privatisation trends at the time:

- Increased reliance on national procurement systems which will favour larger national and international firms rather than local and regional firms;
- More large multi-service facilities management

contracts and large single contracts for goods such as food also favour large national suppliers;
- Long-term contracts thus reducing flexibility for NHS bodies and local authorities;
- Further privatisation of the health infrastructure with management and operation increasingly provided by the private sector;
- Loss of democratic accountability;
- Difficulty in establishing local contracts because national purchasing agencies focus almost solely on financial benefits from economies of scale;
- Government subsidy of low wage employment through income support and family credit (Escott and Whitfield, 1995).

The situation in 2015 is considerably worse because marketisation and privatisation has extended to a wider range of services and functions with the following consequences:

Contract culture

- Core services are now being outsourced;
- The local and regional health and social care economy is more fractured as contractors use their established national sourcing of staff, goods and services;
- Consolidating contracts into a lead supplier model runs the danger of creating a few large monopoly providers;
- The contract culture and commercial values undermine the ethos and principles of the NHS and public service provision;
- Continued low pay, few benefits and job insecurity results in high staff turnover and vacancy rates that ultimately reduce the capability to increase productivity and integrate services;
- Government subsidy of low wage jobs has continued to increase (see Part 9);
- An increasing proportion of the health and social care workforce do not have an occupational pension. This will increase the future demand on the welfare state as they may be solely reliant on the state pension, unless they obtain income f rom employment in retirement;

More frequent financial crises

- More NHS Trusts will be in financial crisis and the government will be forced to increase the bailout fund.
- Further public spending cuts up to 2017-2018 will not only significantly reduce the ability of the NHS and local government to meet health and social care needs, but will make the achievement of integration and other policy objectives extremely difficult.

Making markets, creating profits

- The health and social care PFI infrastructure is increasingly privately controlled by offshore infrastructure funds or private equity funds;
- Resources will be increasingly diverted from frontline services to finance procurement, marketisation and privatisation processes and further reorganisation as more services are outsourced.

Limited reform

- Integration may be the objective, but fragmentation will be pervasive as contractors operate to maximise their own vested interests;
- More and more caring responsibilities will be imposed on families and neighbours;
- The Dalton Review proposals for successful and ambitious NHS Trust boards to develop an enterprise strategy and consider management contract and acquisition opportunities (federations, joint ventures, service level chains, management contracts, integrated care organisations and multi-service chains or Foundation Groups) of other NHS Trusts will have negative democratic and regional economy impacts. It will inevitably create a new market in predatory takeover and merger activity. Trusts with PFI projects in persistent financial difficulty would be included in 'batched procurements'.
- PFI and PPP strategic partnership contracts have enabled the private sector to widen the scope of support service outsourcing. Successive governments' promotion of the choice and personalisation agendas has allowed the private sector to provide clinical services in treatment centres and a widening range of community/ primary care services. There is a very strong rationale that public goods should be publicly owned and delivered. However, there is no discernable operational boundary between the construction and operation of support and core services in buildings, such as clinical services in hospitals.

The next section examines the impact on jobs in the health and social care economy.

Part 6 Impact on jobs

Marketisation and privatisation have led to further deregulation and casualization in the health and social care economy. This section assesses the impacts in the North West, the public subsidy of employer's low pay practices and the causes of the care crisis.

Summary of social care workforce in the North West

24,068	below the minimum wage
45,585	on zero hour contracts
99,770	earning below Living Wage
24%	turnover rate for care workers
27.8%	full-time women and 20% men in workplace pension scheme*

*earning less than £300 per week in 2013 (ONS, 2014)

UK workers suffered a huge squeeze on incomes with average pay falling by 6.3% in real terms since 2007, a loss of £30.30 for employees working a 40-hour week. The North West was the hardest hit region in the UK where the average pay hourly rate fell from £11.43 in 2007 to £10.52 in 2012, leading to full-time workers in the region taking home £36.41 less in real terms a week (TUC, 2013).

Pay and conditions in the care sector

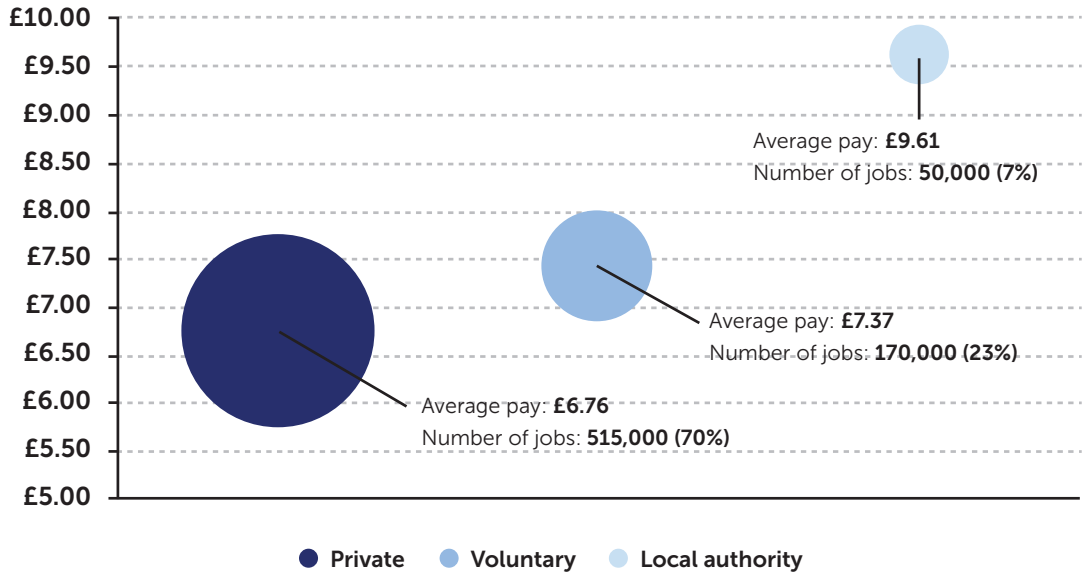
A £2.85 average hourly pay gap existed between 50,000 local authority social care workers and 515,000 care workers employed by private contractors (Figure 9). The 170,000 voluntary sector care workers were only 61 pence per hour better off than the private sector.

Nationally it is estimated that 160,000 to 220,000 care workers are paid less than the National Minimum Wage (Kingsmill Revue, 2014). HM Revenue & Customs found a high level of non-compliance with the National Minimum Wage after investigating 225 employers in the social care sector between April 2011 and March 2013. Completion of 183 enquiries identified £338,835 arrears for 2,443 workers. A further forty-one employers were under investigation which indicated non-compliance in 13 cases with £80,000 pay arrears due to over 2,000 workers (HM Revenue & Customs, 2013). The cost of eradicating minimum wage non-compliance in UK social care frontline jobs was estimated to be £142m in 2013-14 (Gardiner and Hussein, 2015).

Living wage

There were an estimated 611,000 people, 24% of the total North West workforce, earn less than the Living Wage in 2014 (Markit, 2014). The living wage is an hourly minimum wage based on the basic cost of living (Table 38). It contributes to reducing poverty, improves living standards and reduces income and health inequality (Public Health England, 2014).

Figure 9: **Mean hourly rates for care workers by sector, England, December 2012**



Source: Skills for Care, 2013c.

Table 38: **Top three sub-regions below living Wage in the North West**

Rank	Sub-region	Total jobs	Median wage	% below Living Wage
1	West Lancashire	49,000	8.88	41
2	Blackpool	49,000	9.30	33
3	Rossendale	16,000	8.94	33
	North West	**2,593,000**	**10.80**	**24**

Source: Markit, 2014

Some 320,000 of the national care and home care workforce of 701,000 are below the Living Wage (ibid). Only sales and retail assistants and kitchen and catering assistants have a larger number of people below the Living Wage. If the national ratio of 45.6% of care workers earning below the minimum wage is applied in the North West, then 99,770 of the North West social care workforce could be earning less than the Living Wage.

The cost of paying the living wage to the UK social care frontline workforce for publicly funded services procured by local authorities was estimated to be £1.4bn in 2013-14. The net public cost would reduce to £726m on account of higher personal tax receipts and lower benefit payments (Gardiner and Hussein, 2015).

Zero hour contracts

An Office for National Statistics (ONS) business survey in January/February 2014 indicated there were 1.8m employee contracts that did not guarantee a minimum number of hours. Women accounted for 55% of contracts (ONS, 2015). Nearly two thirds of people employed on zero hour contracts work part-time compared with around a quarter of people not employed on these contracts. Health and social work accounted for 241,469 workers nationally on zero hour contracts, or an estimated 35.735 in the North West.

15 minute care visits

The percentage of local authorities commissioning 15 minute visits increased to 74% in 2014 compared to 69% a year earlier (UNISON, 2014). The survey revealed 110 local authorities commission 15-minute visits, which account for 14% of home care visits. The Cavendish Review (2013) into Healthcare Assistants and Support Workers in the NHS and social care settings reported 15-minute visits accounted for 10% of visits in 2012.

Non-payment of travel expenses

A UNISON social care survey revealed 58% of members were not paid for travel time between visits or adequate fuel allowances and 25% spent over six hours each week in unpaid travel time. There was a stark difference between employers – 89% of local authorities paid the allowances but only 19% of private and voluntary sector contractors (UNISON, 2012a).

High turnover rates

The staff turnover rate for the social care sector is 18.6% in the North West, slightly below the 20.6% rate for England. However, the turnover rate for care workers is significantly higher at 24% and 25.9% respectively (Skills for Care, 2013b).

Lack of training and career opportunities

The separation of commissioning and service delivery, coupled with deregulation and casualisation of the social care workforce and increasing outsourcing, has fractured provision and imposed severe constraints on career opportunities for care workers. It is very difficult for the bulk of care workers to move vertically from frontline provision to a position in commissioning. Similarly, insecurity in contracting makes horizontal career progression difficult and unpredictable.

Abuse of personal assistants

The growth of personal budgets and direct payments has led to a corresponding increase in the role of personal assistants. A small survey of personal assistants found evidence of verbal abuse (Skills for Care and Institute of Public Care, 2014). Personal assistants *"...face unique risks and challenges associated with their isolation and vulnerability, working often in people's own homes (not unlike the risks and challenges of their employers). Like their employer, PAs are also potentially vulnerable in one-to-one situations, lacking back-up if needed and without a witness if something happens"* (ibid).

Lack of contract monitoring

Although the Care Quality Commission (CQC) inspects care homes and domiciliary care services, it currently does not have a remit to inspect conditions of employment. The Kingsmill Review (2014) recommended a care provider licence should only be issued if they *"...provide evidence that they meet legal*

standards for workers, and an active, intelligence-led inspection regime, combined with the threat of fines, should serve to check that this is the case. To operate effectively within existing resources, the CQC should concentrate resources on parts of the sector that are associated with abuse and exploitation, based on intelligence".

This must not remove NHS Trust and local authority responsibility to rigorously monitor care contracts, although this alone will not be fully effective, because many contracts are awarded with an understanding, if not knowledge, of the contractor's probable pay rates. Minimal contract monitoring to reduce commissioning costs exacerbates the situation.

Pay rates in the health and social care economy

The mean annual basic pay of a sample of job roles in the NHS (Table 39) are contrasted with the whole time equivalent annual pay of a sample of job roles in adult social services in North West region adult social care (Table 40).

Table 39: **Mean annual basic pay of NHS staff (May 2014)**

Job role	Mean annual basic pay £
Consultants (including Directors of public health)	£88,816
Consultants (including Directors of public health) - locum	£83,663
Senior managers	£78,274
All HCHS doctors (locum)	£75,305
Hospital practitioners & clinical assistants	£67,337
All HCHS doctors (non-locum)	£59,065
Managers	£48,905
Registrars	£37,359
Total qualified scientific, therapeutic & technical staff	£34,505
Qualified nursing, midwifery & health visiting staff	£30,753
Other doctors in training	£25,989
Central functions	£24,910
Support to clinical staff	£18,597
Support to doctors & nursing staff	£18,395
Support to scientific, therapeutic & technical staff	£19,399
Support to ambulance staff	£19,028
Hotel, property & estates	£17,266

Source: HSCIC, NHS Staff Earnings to May 2014, Provisional.

Table 40: **Whole time equivalent annual pay of adult social services in North West region (2014)**

Job role	£ per annum
Middle management	43,400
First Line Manager	34,900
Social Worker	31,200
Supervisor	28,300
Social Care Worker	24,400
Administrative or office staff	18,600
Care Worker	17,300
Ancillary staff not care providing	15,200

Source: Health & Social Care Information Centre (2014a)

The median annual pay for all UK employees was £33,475 in 2014 (Office for National Statistics, 2014d).

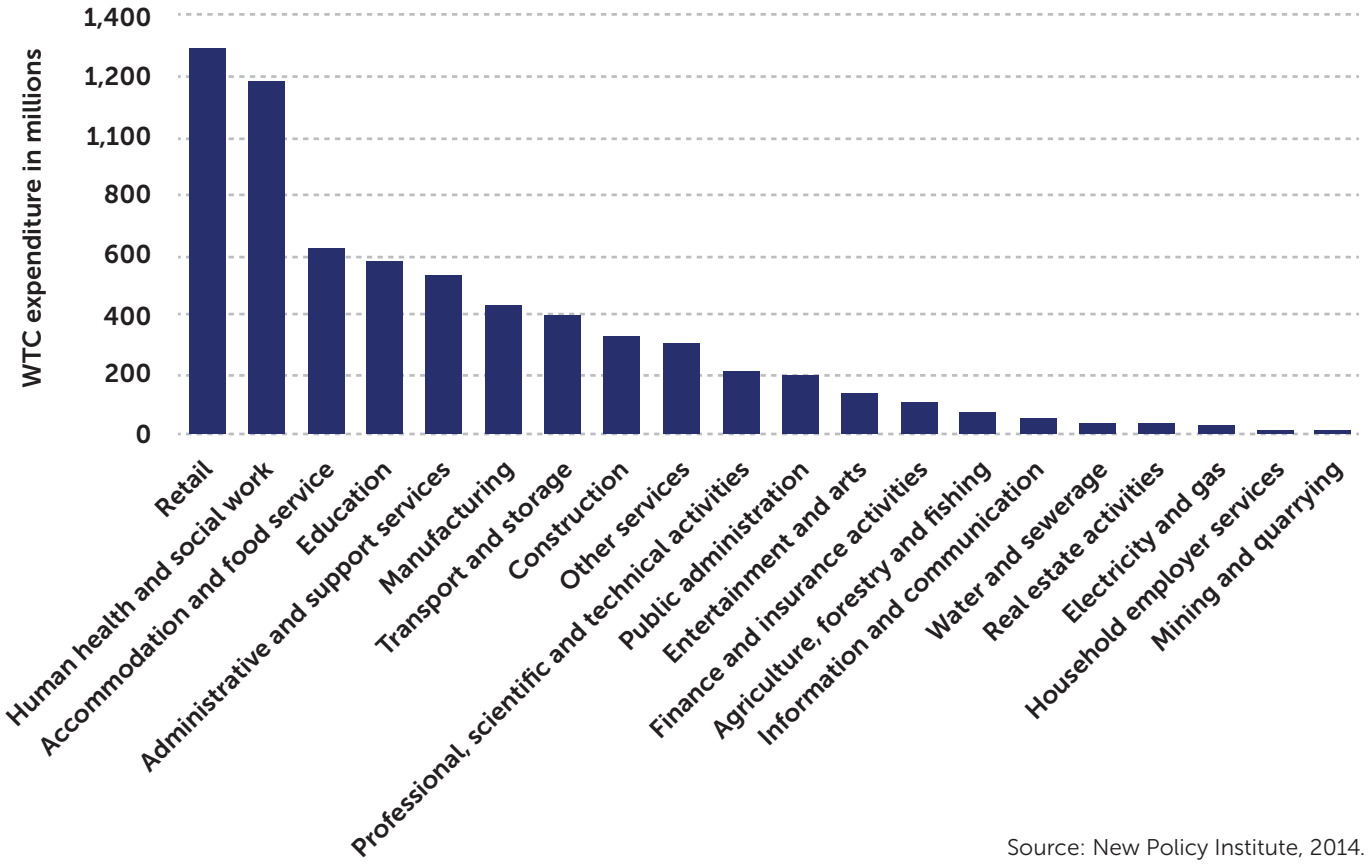
Public subsidy of low pay employers

The Working Tax Credit (WTC) is an income-tested refundable tax credit depending on family composition (basic, couple and lone parent element), health (disability and severe disability element), number of hours worked (30 hour element) and age of claimant (50+ element). Private sector workers account for 80% of WTC followed by 10% in local government and 5% employed in the NHS (New Policy Institute, 2014). The health and social care sector accounts for £1.2bn of the £6.5bn annual expenditure on WTC (Figure 10). There is no figure for the public-private division of the £1.2bn. However, given the level of outsourcing of social care and the relative terms and conditions, it is estimated the private sector accounts for about three-quarters or £900m of the health and care WTC expenditure.

The North West accounts for 12.3% of the 4.1m health and social care sector employment in Britain (Office of National Statistics, 2014b). The North West share of the annual £1.2bn WTC expenditure in the health and social care sector was approximately £147m in 2011-2012 (New Policy Institute, 2014).

In other words, the government is spending an additional £900m annually subsidizing the low pay practices primarily of private contractors. It is a significant expenditure that is rarely, if ever, taken into account in the evaluation of tenders. Clearly, integrated health and social care provision should be accompanied by whole public sector cost analysis in addition to strategies to eradicate low pay.

Figure 10: **Total Working Tax Credit expenditure attributed to each sector**



Source: New Policy Institute, 2014.

Low paid health and care workers are unlikely to contribute to taxation, an occupational or personal pension scheme, and may have multiple jobs with a negative impact on their health and circumstances. A system based on minimalist pay and conditions and training cannot be expected have unfettered commitment to integrated care, particularly those employed by private contractors who seek to maximise profit. There is a contradiction that government, NHS, local government and private health and social care employers will operate support or system that increases poverty and weakens commitment to social justice and reducing inequalities.

Causes of the care crisis

A combination of factors, some longstanding and other more recent, are at the root cause of the crisis in care services. Bold action is needed to reverse current trends that have led to increasing casualization, particularly of the social care workforce, and a deepening crisis.

Firstly, public spending cuts – although NHS budgets have had a degree of 'protection', local government has borne the brunt of cuts. Increased demand as a result of demographic change has increased pressure on declining resources.

Secondly, neoliberal public management's commitment to competition and markets has led to the separation of client and contractor responsibilities. This has enabled the client to absolve responsibility for the terms and conditions for care staff, aided by perceptions about the value of care work, and in particular 'women's' work.

Thirdly, the imbalance of resources between the £121bn NHS budget and the £8bn local authority budget for social care, despite repeated policy initiatives to restructure the healthcare system to increase resources allocated to community care.

Fourthly, the growth of a care market, primarily through outsourcing and the sale of residential care homes, to drive down the cost of care, irrespective of the consequences for care workers and the impact on the local economy.

Fifthly, commissioning care from a range of providers, often with no guaranteed hours following the switch from block contracts to framework agreements; the

award of contracts, often to the lowest bidder, devoid of good employment clauses; inadequate monitoring and contract management; and the exclusion of employment terms and conditions from the remit of regulatory and inspection regimes.

Finally, the current crisis is also creating longer-term intergenerational problems as a result of the loss of pension provision for care workers. Low wages make personal contribution to a pension scheme almost impossible. And those who continue with a pension scheme may find the employer and/or employee contribution could be inadequate to fund an adequate pension.

Agreements and charters

The Kingsmill Review recommendations and best practice agreements such as UNISON's Ethical Care Charter and the TUC and Children England joint agreement on 'intelligent commissioning' of children's services, are designed to improve the procurement and contracting process and the quality of employment (Kingsmill Review, 2014; UNISON, 2012b and Children England and TUC, 2014).

However, they accept the continuation of commissioning and procurement to select care providers and make few proposals to increase the in-house provision of social care.

Unsustainable strategy

Prioritising the *quantity* of service by driving down terms and conditions is unsustainable for the following reasons:

- Increases staff turnover and vacancies leading to higher human resource costs;
- Ultimately means that staff have fewer skills and experience;
- Reduces the quality of services ultimately leading to increased user complaints, dissatisfaction and potential challenge by inspection regimes;
- Reduces the ability of the employer to train staff;
- Reduces the morale and commitment of staff, many of whom may have other part-time jobs;
- Engaging staff in initiatives to improve service delivery, efficiency, productivity and or reorganising services will be more difficult and less effective.
- Negative impact on the local economy because staff will suffer a loss of net household income to spend on goods and services, which supports local employment.
- Women account for about 95% of the social care workforce, hence current employment practices have increased income and employment inequalities.
- The hidden subsidy in the Working Tax Credit that supports low pay contractors and distorts the real cost of healthcare is likely to increase if current circumstances continue as care staffing increases in response to the growing elderly population.

'Doing more with less' is misleading and erroneous. Short-term responses have turned into long-term policies under the guise of 'there is no alternative'. New care models and integration are unlikely to achieve genuine and effective care in the community, with the NHS continuing to absorb the high cost of this failure, until social care is equally valued and funding is available to end the exploitative, if not Victorian, employment policies.

Part 7 Social justice and inequalities in the health and social care economy

Health inequalities

The 2014 health profile of Sefton identifies health inequalities in the local authority:

- Deprivation is higher than average with about 20.9% (9,800) of children living in poverty;
- Life expectancy for men is below the England average;
- Life expectancy is 12.0 years lower for men and 10.5 years lower for women in the most deprived areas of Sefton than in the least deprived areas;
- 20.1% of Year 6 children are classified as obese and 23.6% of adults were classified as obese in 2012 and the estimated levels of adult excess weight are worse than the England average (Public Health England, 2014)

The six Liverpool City Region boroughs were performing "significantly worse" than the England average in 2013 in terms of the proportion of 16-18 year olds not in education, employment or training; hospital admissions of under-18 year olds due to alcohol specific conditions between 2008-2011; and the percentage of mothers initiating breastfeeding and/or percentage of mothers breastfeeding at 6-8 weeks in 2011-2012 (ExUrbe, 2013).

Life expectancy for men in the North West was 77.4 years between 2009-2011, the lowest in England: women were joint lowest with the North East at 81.5 years. The proportion of children living in workless households in the North West, in the second quarter of 2013, was 17.8% compared with 13.6% for England and 9.7% in the south east region (Office for National Statistics, 2013).

In 2011-2012, 21% of the UK population were in poverty after taking account of housing costs. In the same year, 21% of working-age households without children, 35% of those living in households with children, and 9% of pensioners, were living on an income below the minimum standard. (Public Health England and UCL Institute of Health Equity, 2014b).

Part 6 reported that an estimated 611,000 people, 24% of the total North West workforce, earn less than the Living Wage in 2014. Nationally, an estimated 5.28m people, 22% of employee jobs in the UK, earn less than the Living Wage (Markit, 2014).

This is only a snapshot of health and economic inequalities in the region as a more detailed assessment is not within the remit of this analysis.

Government adjustments for health inequalities

The Department of Health applied a weighting of 15% to the funding of primary care trusts in 2009-2010 and 2010-2011 to take account of health inequalities. It was cut to 10% for subsequent years (National Audit Office, 2014a). The Department of Health commissioned the Advisory Committee on Resource Allocation *"...to develop a formula with no health inequalities adjustment"* for 2013-2014 ((ibid). NHS England believed this would risk increasing health inequalities and commissioned the Advisory Committee to draw up a health inequalities adjustment for CCGs – 10% of the target allocation – which was adopted for 2014-2015.

This adjustment benefited the North West and some London boroughs. The target allocation increased by more than 3% for 25 CCGs and decreased by more than 3% for 9 CCGs. NHS England adjusted 15% of the target allocation for each area teams for health inequalities as a more effective way of reducing health inequalities. The National Audit Office conclude that areas *"...with low life expectancy (which tend to be deprived) tend to have fewer elderly people..." thus "... increasing funding for areas with low life expectancy will tend to reduce funding in areas with more elderly people. In other words, there appears to be a trade-off between addressing health inequalities and not reducing funding in areas with ageing population"* (ibid)

Increased inequality

New research has revealed that the gap between rich and poor is at its highest level in most industrialised countries, including the UK, in 30 years (Organisation for Economic Cooperation and Development, 2014). The analysis *"...suggests that income inequality has a negative and statistically significant impact on*

medium-term growth." Rising inequality on the scale recorded by the OECD *"...would drag down economic growth by 0.35 percentage point per year for 25 years: a cumulated loss in GDP at the end of the period of 8.5 per cent"* (ibid).

The OECD conclude that the biggest factor for the impact of inequality on growth *"...is the gap between lower income households and the rest of the population"* and that strategies should tackle the problem of low income and not just poverty (ibid).

Decline in labour share of national wealth

The gap between productivity and pay has increased markedly in industrialised countries since 1999. Average labour productivity increased more than twice as much as average wages (International Labour Organisation, 2013). Figure 11 illustrates how capital captured the bulk of the benefits of increased productivity between 1999-2013.

Social justice in the North West

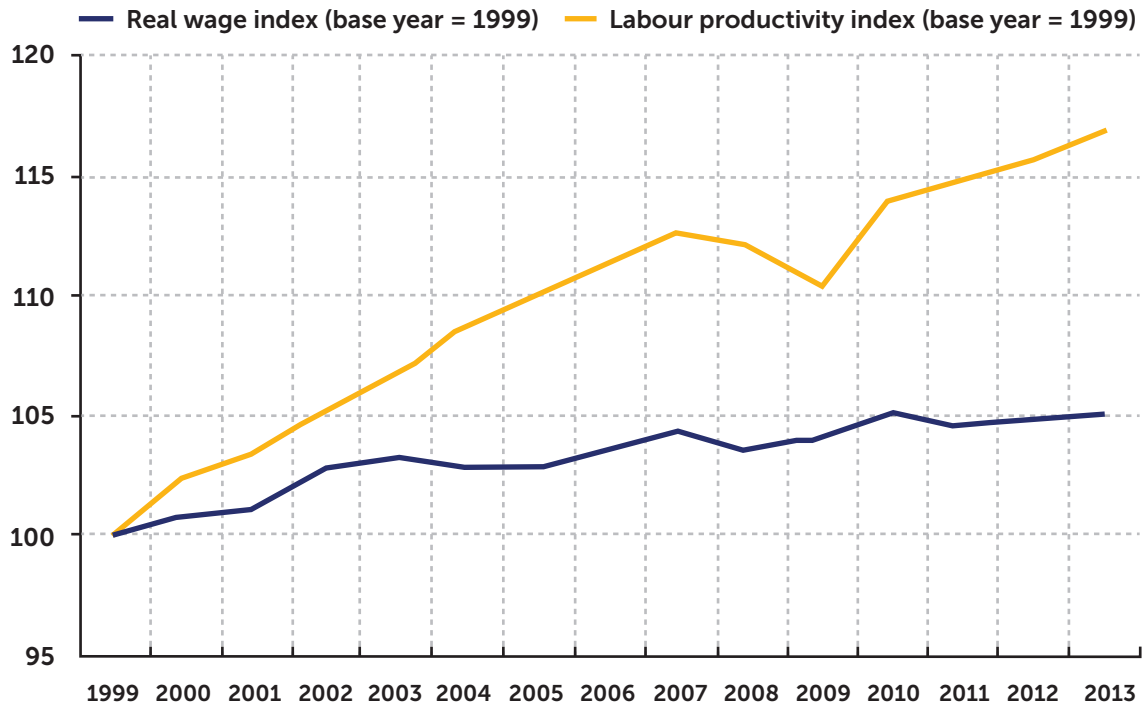
A combined political economy and social justice approach is essential to address the different elements of inequality and to avoid a narrow and limited focus on either health, economic, social or political dimensions of inequality.

A six-part definition of social justice was used to assess regional performance in the Economic and Social Audit for the North West that is not limited to inequalities (North West Regional Assembly, 2005):

- Distribution of opportunities in the region
- Redistribution and improving life chances
- Reducing inequalities
- Eliminating discrimination
- Improving quality of life and community well-being
- Participation, involvement and governance

It is strongly recommended that a social justice approach should be adopted in any further analysis of the health and social care economy in the North West.

Figure 11: **The widening gap growth in average wages and labour productivity** (Index: 1999=100)



Note: Labour productivity is defined as GDP per employed person and uses GDP in constant 2005 PPP$ for all countries. G20 advanced economies include: Australia, Canada, France, Germany, Italy, Japan, the Republic of Korea, the United Kingdom and the United States. Both indices are based on a weighted average of all the countries in the group that takes into account labour productivity and the size of paid employment..

Source: ILO staff estimation, using data from the ILO Global Employment Trends report and the ILO Global Wage Database, revised and updated.

Part 8 Regional industries, research and health provision

Healthcare industries and clusters, the growth of biomedical research centres, the national life sciences strategy, and the Academic Health Science Networks and innovation have vital roles in the regional health and social care economy.

Healthcare industries in the North West

The North West is a major biomedical cluster (the application of the natural sciences, especially the biological and physiological sciences, to clinical medicine) with over 200 companies in the biotechnology, pharmaceutical and healthcare industries that employ over 20,000 people. The region has the largest cluster of advanced flexible materials manufacturers (which includes textiles), in Europe and accounts for two-thirds of UK manufacturing capacity.

The North West had 12,400 employees in pharmaceutical manufacturing in 2010, which accounted for 21% of the Great Britain total (Skills of Health et al. 2010). Seven multinational pharmaceutical companies have plants in the region (AstraZeneca (including Medimmune), GlaxoSmithKline (GSK), Sanofi Aventis, Eli Lilly, BMS and Novartis). Astra Zeneca is relocating its largest global research centre with 1,600 jobs to Cambridge, although its manufacturing plant with 3,000 employees will remain in Macclesfield. Its research facilities at Alderley Park will become a new biohub.

GSK is expanding its Ulverston, Cumbria, plant with a new facility to manufacture biopharmaceutical medicines for treating cancer, autoimmune and hereditary ailments. It will create about 250 jobs but is not scheduled to be fully operational until 2021 (www.pharmaceutical-technology.com).

Advanced flexible materials manufacturing is concentrated in central Lancashire and the northern part of Greater Manchester. Over 480 advanced flexible materials companies employ 37,000 people in the region with a total turnover of £4bn and 70% of sales generated by exports. The textiles industry is particularly important for the manufacture of workwear and textiles in the medical, aerospace, industrial, automotive and construction sectors.

Liverpool and Manchester biomedical research centres

A new biomedical facility is planned at the new Royal Liverpool University Hospital to add to several existing research centres such as the Cancer Research UK Centre, the Wolfson Centre for Personalised Medicine (one of only three in the world), and the Centre for Materials Discovery, all based at the University of Liverpool.

One of the eleven new Genomic Medicine Centres will be located in Liverpool as part of the national 100,000 Genomes Project (the complete set of DNA and all the inheritable traits of an organism). The Liverpool-based North West Coast NHS Genomic Medicine Centre, a partnership led by Liverpool Womens Hospital alongside Liverpool Health Partners will involve other North West NHS Trusts.

The National Institute for Health Research's Manchester Biomedical Research Centre was established in 2008 to accelerate scientific breakthroughs from the laboratory, through clinical trials and into practice across the NHS to improve patient care. The Centre, a partnership between Central Manchester University Hospitals NHS Foundation Trust and the University of Manchester, is a specialist centre of excellence in genetics and developmental medicine.

Life sciences national strategy

The government launched an industrial strategy in life sciences to attract new investment, create new jobs and strengthen NHS leadership in health research (Department for Business, Innovation and Skills, 2011). Life sciences includes any science that deals with living organisms, their life processes, and their interrelationships, such as biology, medicine, or ecology.

North West NHS Innovation

TRUSTECH is an NHS organisation and part of a national network of NHS innovation hubs that helps to identify and develop innovations such as medical devices or equipment, diagnostic or screening tools, education and training materials, software or information services. The aim is to *"...turn new*

ideas into products to meet the demands of future healthcare, and help spread innovative ideas across hospitals and community settings to improve patient care" (http://www.trustech.org.uk). TRUSTECH provides an innovation management service for NHS organisations in the North West and UK companies from the Manchester biomedical research centre with offices in Liverpool and Daresbury. The organisation assesses innovations developed by Trust staff to see if they could be developed into commercial products or services and advises how they can protect their innovations. It also provides support on how to commercialise innovations, funding sources, identify commercial partners and negotiate agreements.

The North West Fund for Biomedical provides £50,000 to £1.5m to companies operating in the Biomedical Sector, such as pharmaceuticals (research, development and manufacture of drugs and biop-harmaceuticals); biotechnology; diagnostics; clinical research organisations; contract manufacturing organisations; analytical services and sciences; and healthcare technologies and medical devices.

The region also has several Clinical Research Facilities for experimental medicine at Alder Hey Children's NHS Foundation Trust, Central Manchester University Hospitals NHS Foundation Trust, The Christie NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust. The four centres are part of UK Clinical Research Collaboration, which has £102m funding between 2012-2017.

Drive to accelerate innovation

The North West has two Academic Health Science Networks – North West Coast (West Cheshire, Merseyside, Lancashire and South Cumbria) and Greater Manchester (including East Lancashire and East Cheshire) – with north Cumbria included in the North East and North Cumbria AHSN as part of 15 academic health science networks recently funded by the government.

They will work between the NHS, universities and industry to speed up the adoption of innovation, promote collaboration and co-development, and to identify and address unmet medical needs. *"AHSN have been established as autonomous bio-enterprises & small/medium enterprise in nature, with a five year licence commitment from NHS England. The relationship is one of investor return rather than traditional service provision and programme management. AHSNs are not the "delivery vehicle" for NHS England national programmes"* (http://www.england.nhs.uk/ourwork/part-rel/ahsn/).

A new NHS England Innovation Accelerator programme was launched in January 2015 inviting international health care innovators to examine how tried and tested innovations in other countries can be applied and developed in the NHS.

Part 9 Demographic change and demand forecasts

Demographic change, particularly the aging of the population, will make significant additional demands on the NHS and local authority services. This section addresses the scope and geography of these changes, their potential impact and adult social care workforce projections.

Demographic change in the North West

The population of England is forecast to increase 7.2% between mid-2012 and mid-2022, but with significant regional variations, particularly in the age profile. The North West population is forecast to increase by 258,000 to 7,342,300 or 3.6%, half the growth rate of other regions. Only the North East has a lower growth rate (Office for National Statistics, 2014e).

The 0-15 years age group is forecast to increase by 5.7%, a decline of 1.3% in the 16-64 years old age group and a 19.6% increase in the 65 and over age group. The latter is the small percentage increase of the over 65-age group in all regions and compares with a 22.4% increase in England.

Population change in the North West is forecast to occur primarily for natural change (3.1%) with the remaining 0.5% from total migration. International migration would increase by 1.1%, offset by negative internal migration of 0.6% (ibid).

Eight of the ten local authorities with the lowest projected population growth in England between mid-2012 and mid-2022 are in the North West – Barrow-in-Furness, Copeland, Hyndburn and Blackpool with a projected decline in population ranging from -1.8% to -0.2%; Burnley and Allerdale with no projected change in the population; and South Lakeland and West Lancashire with projected increases of 0.2% and 0.5% (ibid).

Sefton has highest percentage population aged 65 and over

The population aged 65 and over is 20.8% in Sefton, the highest in the North West and contrasts with the 9.4% Manchester with the lowest at 9.4% (Table 41).

Table 41: **Geographic variation of population of older people in North West** (2011)

Local authority	Total population	Population 65 and over	% population 65 and over
Sefton	**273,790**	**57,011**	**20.8**
Cumbria	499,588	102,889	20.6
Cheshire East	370,127	71,372	19.3
Blackpool	142,065	27,239	19.2
Wirral	**319,783**	**60,966**	**19.1**
Cheshire West & Chester	329,608	61,100	18.5
Lancashire	1,171,339	211,193	18.0
Stockport	283,275	51,027	18.0
St Helens	**175,308**	**31,400**	**17.9**
Wigan	317,849	51,649	16.2
Trafford	226,578	36,273	16.0
Bury	185,060	29,540	16.0
Warrington	202,228	32,214	15.9
Knowsley	**145,893**	**23,014**	**15.8**
Tameside	219,324	34,201	15.6
Bolton	276,786	42,540	15.4
Halton	**125,746**	**18,481**	**14.7**
Oldham	224,897	32,953	14.7
Rochdale	211,699	30,816	14.6
Salford	233,933	33,206	14.2
Liverpool	**466,415**	**65,466**	**14.0**
Blackburn with Darwen	147,489	19,061	12.9
Manchester	503,127	47,544	9.4

Source: Focus on the Health and Care of Older People, HSCIC, 2014e.

The population aged 65 and over is forecast to increase by 56% in the 2010-2035 period compared to a 4.8% increase in the 20-64 age group (Table 42). The increase in the older population accounts for two thirds of the region's increase in population in this period.

Table 42: **Population projections for the North West 2010 – 2035** (thousands)

Year	Population aged over 65	Population aged 20-64	Total population
2010	1,160	4,112	6,939
2015	1,297	4,176	7,159
2020	1,396	4,230	7,380
2025	1,515	4,242	7,586
2030	1,675	4,253	7,766
2035	1,810	4,309	7,931

Source: Skills for Care – nmds-sc data set, October 2013.

A long-term forecast indicates that 65-74 and 75-84 age groups continue to increase up to about 2031 and 2041 respectively and then stabilise. However, the over 85-age group is forecast to continue increasing as a proportion of the population up to at least 2051 rising from 2.66% of the population in England in 2011 to 8.91% by 2051. The over 65-age group will nearly double in six in the same period (Skills for Care, 2013). This forecast projects a population increase of 772,000 in the region (10.8%) between 2015-2035. The over 65-age group and the under 65 age group will represent 66.45% and 33.55% respectively of the population increase.

A 10.8% increase on current provision and direct employment would be 47,215 jobs in the region. Taking account of the increase in the over 65 age group and the different multipliers in health and social care calculating the indirect and induced employment, the total employment impact will be 53,335 plus 23,760 = 77,095 jobs.

However, other factors must be taken into account:

- The potential increased productivity across the health and social care system between 2015 and 2035 ie over the next twenty years.
- Increased application of telemedicine and telehealth and new technologies, which may lead to improved productivity. However, this could be cancelled out by technology increasing access and thus the demand for health care.
- Increases in the standard of living, leading to rising demand for more comprehensive and better quality of services.
- The risk of new threats from diseases and illnesses caused by continuing globalisation of economies, thus increasing demand on health and social care services. These risks are very difficult to predict.
- The performance of UK, European and global economies over the next 20 years cannot be forecast with any degree of accuracy. The possibility of further economic crises cannot be ruled out.

If a 1% productivity increase is achieved across the health and social care economy every year for the next 20 years, the total employment cumulative impact will be 63,065 jobs. This is an optimistic forecast because healthcare productivity increased by an average 0.5% between 1997-2010 and adult social care productivity decreased 1.7% per annum in the same period. The overall figures were a 6.2% productivity increase for healthcare, but a 20% decrease in adult social care (Office for National Statistics, 2014f).

It could be argued that the productivity/efficiency benefits of the increased application of new technologies would be virtually the same as increased demand for more comprehensive and better quality services, which are labour intensive and cannot be mechanised. Therefore, it seems reasonable to plan for a 63,000 increase in employment in the North West health and social care services by 2035.

The next stage is to determine where this growth might occur in the region. Subnational local authority population forecasts do not extend to 2035. However, given the planned infrastructure investment and city growth forecasts and the 2012-2022 forecasts noted above, it is reasonable to assume that Liverpool and Greater Manchester City Regions will be the main magnets for economic and population growth. A broad estimate is that about 45,000 - 50,000 of the new 63,000 jobs will be in, or within commuting distance of, the two city regions.

Scenarios for the future adult social workforce in England

Skills for Care developed four projections for the future adult social workforce in England. The additional North West estimate is based on a pro rata, taking account of demographic change forecasts.

The *Base Case* scenario assumes the 2008-2009 pattern of service continues at a constant rate while demand for services increases as anticipated. The number of jobs could increase by about 50% to 2.4m in 2025.

The *Maximising Choice* scenario assumes the demand for publicly funded home care will be met, which would lead to employment reaching 2.6m (by 60%) by 2025. But most jobs will be personal assistants.

The *Contain and Community* scenario assumes most care and support would be provided by a largely unpaid workforce of family carers and community volunteers. The workforce would be responsible for managing resources and providing support. Employment would increase by 27% to 2.1m in 2025.

The *Restricted Resources* scenario assumes future resources for adult social care will be very limited with stringent assessments and reviews, increased

community advice and guidance services and higher client-staff ratios in publicly-funded residential care. Employment would increase by 19% to just over 1.9m.

These scenarios indicate an increase in the adult social care workforce in the North West of between 40,300 and 125,500 jobs by 2025 (Table 43).

Table 43: **Adult social care workforce projections in England 2012-2025** (Thousands)

Scenarios	2012 (000)	2015	2020	2025	Change 2012-2025 England (000)	Change 2012-2025 North West (000)
Base case	1,630	1,770	2,065	2,395	765	99.5
Maximising choice	1,630	1,800	2,165	2,595	965	125.5
Contain & Community	1,630	1,735	1,905	2,070	440	57.2
Restricted resources	1,630	1,700	1,815	1,040	310	40.3

Source: Skills for Care, 2013 Table 4.1. North West figures calculated on 13% of England's forecast population of 54.4m in 2015.

The potential increase in residential care workforce has been estimated using a 2007 base and taking account of changes, such as the number of single older people living alone, high and low levels of life expectancy and 1.5% per annum decrease in the probability of entering a care home, reflecting the strategy to maximise the role of home care. The additional care home workforce needed ranged from 166,400 to 46,000 (Table 44). Of course, a smaller increase in the care home workforce will shift the balance of domiciliary care. For example, a 1.5% per annum decrease in the probability of entering a care home would require a 109% increase in home care staff between 2007-2032 (Personal Social Services Research Unit, 2010).

Table 44: **Projected change in care home workforce, England** (000)

Scenario	2007	2035	No of additional staff (actual)	% change
Base case	168.4	313.9	145,500	86.4
1% increase per annum in single living alone	168.5	317.7	149,200	88.5
High life expectancy	168.4	334.8	166,400	98.8
Low life expectancy	168.4	293.3	124,900	74.1
1.5% per annum decrease in probability of entering residential care (average package)	165.9	211.9	46,000	27.7

Source: Personal Social Services Research Unit, 2010.

Part 10 Reconfiguring the North West health and social care economy

This section examines the importance of more effective integration of services; the digitisation of health and social care; planning and growth in the North West; widening democratic accountability and ways to maximise the benefits of the health and social care economy. It concludes with ten alternative policies that could provide a framework for reconfiguration.

Integrating health and social care

There are different political and operational interpretations of the meaning of integration between health and social care staff patients/service users and variable boundaries depending on the medical/social care needed with regard to the type, breadth, degree and process of integration.

New Delivery Models in North, Central and South Manchester plan to reduce unplanned care admissions and reduce the cost of people with long-term conditions to the system. They aim to:

- *"Demand shift across the health and social care system in Manchester, to enable real and cashable savings to be made and re-invested in evidence based early interventions.*
- *Better health and social care outcomes, including improved management of long-term conditions.*
- *Improved experience for patients / services users and carers – a more coordinated, coherent customer journey; better social connectivity; improved self-reported well being; and improved social independence.*
- *Reduced health and social care costs – particularly acute care costs (e. g. reduced admissions and bed days attributed to people with multiple long term conditions) but also greater efficiencies and de-duplication of services in the community"* (Association of Greater Manchester Authorities, 2014).

A comparative study across three health and social care economies in integrated settings in the UK found that *"integration of care happens 'in practice', as staff and their clients go about their day-to-day work"; "the 'quality of relationships' in teams was more important than content and labels of roles for the way people worked together – or not"; "...much of the 'training' required by more integrated ways of working was undertaken informally on the job, learning and 'picking up skills' from others"* (Huby et al, 2010).

A European Observatory on Health Systems and Policies/European Commission review of the economic impacts of integrated care concluded:

"Evidence that is available points to a positive impact of integrated care programmes on the quality of patient care and improved health or patient satisfaction outcomes but uncertainty remains about the relative effectiveness of different approaches and their impacts on costs" (Nolte and Pitchforth, 2014). The review found that economic impact was often limited, lacked rigor and cost savings were often not statistically significant.

The lack of evidence on cost effectiveness was reinforced by the (Commission on Hospital Care for Frail Older People (2014):

"There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true."

The emphasis of integrated care from an individual's perspective is important (National Collaboration for Integrated Care and Support, 2013), but there is also a collective, public interest and health system-wide perspective of integration.

Integration can be increased through local measures such as:

- Joint working (the location of staff from two or more organisations in one location);
- Pooling of budgets and alignment of objectives;
- Joint planning, ownership and decision-making of projects or services;
- Integrated management and provision of services;
- Workforce training and development to develop culture of cooperation and joint working;

- Use of each CCG's 2% budget allocation for non-recurrent expenditure to develop projects that enhance integration across health, social care, public health and other local authority services.

Integration also requires more fundamental change across the health and social care economy which should include:

- Increased financial resources to social care;
- Re-integration of commissioning and provision;
- Significant reduction of the contract culture.

These initiatives are likely to be more effective than further system-wide organisational change that is almost certain to be more costly, and, under current policies, accelerate marketisation and privatisation of the NHS. Frequent top-down reorganisation of the NHS ultimately destabilises services for a long period, extending from the run-down/transfer of existing organisations to the establishment and initial operation of new ones. The transfer/recruitment of staff causes further insecurity. The extensive use of management consultants in reorganisation often leads to a loss of organisational capability. Furthermore, reorganisation is frequently limited to creating new structures with limited attention given to changing the way services are delivered.

Digital health and social care

Telehealth and telecare and new digital applications will have a significant impact on the future delivery of health and social care. There are inevitably going to be gaps between the capability of digital technology and its application and sustainability in healthcare. The geographic coverage, security, reliability, affordability and sustainability of high-speed broadband remain a key issue. Self-monitoring by the very elderly is another matter. Large numbers of poorly paid social care staff may assist others to use telecare in their job, but currently cannot afford, or don't even have access to, high speed broadband.

A large randomised controlled 12-month trial of telehealth in the UK concluded the intervention incurred additional costs (for participants and GPs) for only a very minimal gain in quality adjusted life years (Henderson et al, 2013). This would indicate that, at least in the short term, the cost effectiveness of telehealth cannot be assumed.

A 'paperless' NHS may be technically possible, but whether it is secure to allow the continuous transfer of patient records between health and social care organisations is another matter. Big data systems will be required and inevitably will be developed at high public cost by the large ICT and software companies. The NHS and social care system will operate these systems, although it is very likely they will not own or operate them directly, but through managed services contracts with very tight data protection regulations. These systems will require a high level of rapid response to system faults and failures. It is not inconceivable that future outsourcing may include ICT firms diversifying to provide health and social care services.

The NHS Integrated Digital Care Technology fund was reportedly reduced from £240m to £43m when the Coalition government transferred funds to help NHS Trusts respond to winter pressures in February 2015 (Local Government Chronicle, 2015).

Planning and growth in the North West

Major infrastructure projects in the North West include the planned HS2 from Birmingham via two routes to Manchester and Leeds and the longer term plan for the HS3 from Liverpool via Manchester and Leeds to Hull.

HS2 is forecast to increase GDP in Greater Manchester by between £1.3bn and £0.6bn per annum, equivalent to between a 1.7% and 0.8% increase in total local economic output in 2037 (High Speed Two (HS2) Limited, 2013). A £255m rail electrification programme for North West rail lines between 2015-2917 includes the Newton-le-Willows to Liverpool Lime Street; Huyton to Wigan, Manchester Victoria to Preston and Preston to Blackpool. The planned Manchester Airport Ordsall Chord improvements will connect Manchester Piccadilly, Oxford Road and Victoria Stations. Demand for peak time rail services into Manchester are expected to increase 37% by 2019.

Up to 25,000 new homes are planned in the North West (Prime Minister and Chancellor of the Exchequer, 2015). An estimated 100,000 new generation of adaptable, care-ready homes for older people, designed with on-site care services, will be needed in England in the next 15 years (National Housing Federation, 2015). Sefton Council is currently examining housing options that could meet the needs of an increasingly older population.

The growth areas provide an opportunity to provide state of the art facilities and public services through

public investment, including a new radical health and social care infrastructure and services. Similar statements were made about public services in the first wave of new towns and overspill schemes developed several decades ago that were never achieved. Hence they need to tested systems, not laboratory models.

Private developers, Local Enterprise Partnerships and other interests are likely to promote private housing development with a minimal level of 'affordable' and public housing to rent. It is equally likely that continuing public investment constraints lead to a new phase of Private Finance Initiative projects for health and social care, education, transport and other infrastructure in the North West.

Continued outsourcing of NHS and local government services could mean that private firms will be in a powerful position to win contracts in the new growth areas. This could have a significant knock-on effect on health and social care services in other parts of the North West as the private sector seeks economies of scale.

Continuing financial constraints could result in a conflict of priorities between the allocation of resources in the new growth zones or investment to tackle inequalities in inner city areas. The pro-growth interests will argue strongly that the new transport infrastructure investment offers a unique opportunity to generate growth and jobs in the regional economy and that the region-wide benefits should be prioritised. This could result in marginalising investment in inner city areas. If current social care employment conditions are replicated in the new growth areas will exacerbate existing inequalities and possibly create new ones, particularly for staff who are employed in growth areas, but cannot afford to live in them.

Democratising the health and social care economy

Part 1 described the key role of democratic accountability and participation in the health and social care economy model. Patient/service user, community organisations and staff/trade union involvement in the planning and design of services is vital to sustain accountability, ensure services are based on community needs and to improve the quality of service.

However, NHS England consistently promotes patient engagement, but rarely refers to staff involvement in transformation, service planning and delivery (for example, NHS England 2014b). It often makes reference to staff wellbeing, but this does not include participation or involvement in the planning and delivery of services. There are even fewer references to trade unions.

Some NHS Trusts in the North West have engaged staff in service improvement initiatives, which need to be developed and sustained. If the ideas, experience and innovation of staff are not harnessed in the reconfiguration of health and social care services, it would be a lost opportunity and limit their effectiveness and benefits.

The Health and Social Care Act 2012 led to the transfer of public health to local government and the establishment of local authority based Health and Wellbeing Boards. The latter are new organisations that have no formal powers, but are tasked with assessing local health needs through the Joint Strategic Needs Assessment process, producing a health and wellbeing strategy to provide a framework for commissioning and to promote joint commissioning, integrated provision and pooled budgets. For example, see Sefton's Health and Wellbeing Strategy 2014-2020 (Sefton MBC, 2014).

Many Health and Wellbeing Boards are widening the scope of wellbeing to include housing, transport and the environment and widening consultation. However, consultation about policies and issues is not the same as involvement in planning and provision. Health and Wellbeing Boards need to be successful in involving the public, patients, service users, staff and community and trade union organisations, but they must not be the only part of the health and social care organisational structure to do so, particularly when they has no formal powers or resources.

Devolution

From April 2016 the £6bn NHS budget for Greater Manchester will be devolved to the Greater Manchester City Region (Combined Authority) followed by an election for Mayor in 2017. This decision has significant potential benefits and negative consequences in equal measure until further details are revealed.

It is reported that the chief executive of a new Strategic Health and Social Care Partnership Board will be responsible for the NHS budget, not the Mayor (Health Service Journal, 2015d). There are pertinent questions regarding the health and social care economy:

- Will devolution mean that Greater Manchester will have the power to develop new health and social care policies or will it, in effect, be a city region of NHS England?
- What will be the powers of, and representation on, the new Strategic Health and Social Care Partnership Board?
- Will the Combined Authority or the Strategic Health and Social Care Partnership Board or a Joint Commissioning Board have the power to instruct CCGs, NHS Trusts and local authorities to stop the marketisation and privatisation of NHS and social care services and instead develop improvement and innovation plans to retain in-house services?
- How will the Combined Authority ensure that the terms and conditions of social care workers are improved through the living wage, the end to zero hour contracts and protected from further cuts in local government budgets?
- How will patients, service users, community organisations, staff and trade unions be genuinely involved in the planning and delivery of health and social care services?
- Will the Combined Authority recommit to reducing health and economic inequalities in Greater Manchester with a specific programme of ring-fenced initiatives?
- Will the Combined Authority commit to building the internal capability of the Authority to minimise the use of consultants?

The Liverpool City Region Combined Authority is currently negotiating for a similar devolution of the NHS and other public service budgets.

The Coalition government's response to the House of Commons Communities and Local Government Select Committee devolution report made no mention of engagement, participation, involvement, community organisations or trade unions, thus revealing an approach to devolution bereft of a concern for participative democracy (HM Government, 2015).

Devolution without democratisation and participation will merely replicate existing power relations and the continuation of current health and social care policies.

Privatisation data

The reporting of health and social care outsourcing contracts by CCGs, NHS Trusts and local authorities and other health public bodies, in addition to the formal OJEU contract award notice, is piecemeal and limited. Without the NHS Support Federation's data collection and publications the situation would be very difficult. The loss of publicly available data such as the type of facilities, number of beds and staffing levels in private nursing and residential homes, hospitals and clinics was noted in Part 4.

Social enterprises and small companies are exempt, under sections 477 and 476 of the Companies Act 2006, from providing a full annual audit of their accounts. Some social enterprises provide only the minimal Abbreviated Balance Sheet, the legal minimum, with no information about turnover, employment, contracts, profit and loss and performance. Some provide additional financial and operational information. Similarly, social enterprise websites vary widely in the provision of financial and operation information. Some provide unaudited social impact statements, but many do not. Some publish detailed Quality Account reports, but others do not.

All organisations operating public contracts on behalf of the NHS, primary care bodies and local authorities must be subject to basic level of financial, operation and performance disclosure. The government, NHS and local authorities should ensure that health and social care contracts and funding agreements include a requirement to disclose this information.

Part 11 Recommendations to strengthen the health and social care economy

If current trends continue, it is conceivable that a 2030 version of the Health and Social Care Economy in the North West would be analysing much deeper problems and crises unless there is a radical change of direction.

Continued marketisation and privatisation of the health and social care economy, in particular the commercialisation of NHS trusts and CCGs, is unsustainable. Claims that the NHS will remain 'free at the point of use' are meaningless if health and social care is largely provided by private companies. This will fundamentally change the scope, range and quality of services and the principles and values on which health and social care is provided. Private companies and finance capital will be in a more powerful position to seek conversion to a mandatory private health insurance scheme.

The recommendations are divided into two parts. Firstly, health and social reconfiguration should urgently address the following priorities:

1. Secure long-term funding for the NHS with an immediate significant increase in local authority social care expenditure, together with a planned return to grant funding of community and voluntary organisations;
2. Begin an immediate roll-back of marketisation and privatisation by cancelling planned procurements; rigorous monitoring and review of outsourced contracts; the replacement of outsourcing with in-house service innovation and improvement plans prepared with staff, patient/user involvement, together with three-yearly service reviews;
3. Stop the transfer of NHS and local government services to social enterprises and trading companies, but increase their role in supply industries and research.
4. Public investment to replace Private Finance Initiative, social impact bonds and other private finance projects for health and social care infrastructure and services.
5. Immediately improve the terms and conditions for low paid workers, particularly in social care, with a living wage and an end to zero-hour contracts;
6. Achieve real and sustainable integration of health and social care services with collaboration and joint working between NHS Trusts, CCGs, local authorities and other public bodies;
7. Maximise regional benefits from closer cooperation between NHS trusts and local authority social care organisations, research institutes, innovation funds and the manufacturing and supply sectors;
8. Draw up local, city region and North West regional plans to develop the health and social care economy, to include housing and health adaption, emission reduction and renewable energy projects;
9. Prioritise local, city region and regional funding and action strategies to tackle health and economic inequalities;
10. Increase democratic accountability, scrutiny and transparency of NHS Trusts, health and social care organisations;
11. Launch a programme to involve staff and patient/user representatives in innovation and improvement, service integration and joint working initiatives;
12. Draw up a staff and management retraining programme to reinforce NHS principles and values, and public service management practice.

Secondly, a series of recommendations grouped under seven headings.

Reconfiguring health and social care

- Local authorities and their care organisations should be proactive in responding to local hospital crises by offering to adjust service provision, such as reablement, to unlock blocked beds and to propose longer-term service redesign. This may involve promoting joint local authority/care organisation initiatives with the capability and flexibility for rapid response.
- Increase the awareness of the scope and importance of the health and social care economy and how its different dimensions can be incorporated into planning and decision-making.
- The North West definition of the health and social care economy should be incorporated into policy-making, project proposals and business cases.

Improvement and innovation

- CCGs, NHS Trusts and local authorities should focus on in-house service delivery options, including a proactive role in developing NHS consortia or partnerships with procurement as a last resort.
- NHS organisations and local authorities should ensure that patient and community organisations are fully involved in health and social care planning and service improvement (particularly those representing equalities groups, staff and trade unions).
- Future health and social care infrastructure investment should be funded by direct public investment accompanied by programmes to maximise local and regional sourcing of construction materials, jobs and training and the supply of equipment and goods.
- CCGs, NHS Trusts and local authorities should strengthen their ability to monitor, review and scrutinise health and social care services. Contractor self-monitoring should form only a small part of an overall contract management policy.
- Health and social care organisations should operate with flatter management structures, devolve more responsibility to frontline staff in delivering services, and encourage innovation and improvement.
- The NHS and local authorities should increase collaboration with research bodies in the region, to promote innovation initiatives and testing/piloting of new technology, medical devices and equipment.
- Imposing employer responsibilities on to budget holders through personal budget direct payments should be strenuously discouraged as it fragments social care provision and increases the casualisation of employment.

Public ownership and investment

- The government must substantially increase the resources for local government and specifically for care.
- The buy-out of PFI projects should only be considered if the government establishes a new Treasury debt-buy-out scheme. They should not be financed by local authorities or other public bodies.
- The outsourcing of NHS and local authority services to private and non-profit contractors should be drastically reduced and sanctioned only in circumstances of exceptional need.
- The purchaser/provider spilt should ultimately be abolished and replaced by policies that prioritise in-house provision supported by Service Reviews and three-year Service Innovation and Improvement Plans. If an in-house service does not achieve the required level of performance and/or significantly fails to implement an improvement, it would be subject to an options appraisal that would include a forward-looking in-house house option developed jointly with staff and service users.
- The function of local CCGs and combined sub-regional CCG's and CSUs should be changed to develop a more integrated health and social care system by advising and supporting NHS Trusts and local authorities. They should ensure the maximum local/regional benefit from the health and social care economy, develop health and social care plans, and finance pilot projects to test the application of new health care technology.
- CCUs must be retained in the public sector, otherwise they are likely to become a vehicle to drive further marketisation and privatisation in the NHS.
- Engage in the consultation of the NHS Reinstatement Bill that will reinstate the government's legal duty to provide the NHS in England; re-establish District Health Authorities (coterminous with local authorities), with family health services committees to administer arrangements with GPs, dentists, and others and abolish competition and marketised bodies.
- Oppose the Transatlantic Trade and Investment Partnership (TTIP) and the Trade in Services Agreement (TISA) free trade agreement that is almost certain to increase the marketisation and privatisation of public services. The TTIP currently includes investor compensation if public bodies return services in-house.

Improving wages and benefits

- The Living Wage should be paid to directly employed staff in health and social care public bodies and a requirement in outsourcing contracts. Health and social care public bodies should monitor compliance and ensure the Living Wage rate is sustained and regularly updated.
- Increased regulation and enforcement of minimum wage legislation.
- Health and social care public bodies that transfer

staff under the TUPE regulations should ensure that contract monitoring includes assessing whether contractors meet their regulatory obligations.
- NHS organisations and local authorities should develop strategies for improving the health and wellbeing of their workforce, drawn up with staff and trade union representatives, and regularly monitored and reviewed.
- Contractor pay rates, pensions, and other terms and conditions, to be taken into account in the quality component in the evaluation of bids.
- The use of zero hour contracts should be abolished and 15 minute care time slots made permissible only in very limited circumstances.
- Statutory guidance should require NHS organisations and local authorities to include payment of travel time as a contract condition for home care providers (Cavendish Review).
- Care Quality Commission inspections of health and social care organisations should be extended to assess staff health and well-being standards and targets, which should include terms and conditions of employment. Currently CQC inspections are limited to staff having the appropriate knowledge, skills and experience, with adequate staffing levels, are well managed and have an opportunity to develop and improve their skills.
- Public, private, non-profit and voluntary sector care providers should immediately implement UNISON's ethical care charter and regularly monitor and review progress.
- NHS employers, local authorities and Skills for Care should develop a career development framework for health and social care staff.

Assessing costs, benefits and impacts

It is vitally important that decisions on the provision of health and social care are preceded by rigorous cost benefit analysis and economic, social, environmental, equality and health impact assessment. Current government practice is selective and inadequate.

- Ensure a full public sector wide cost analysis is undertaken prior to any outsourcing and privatisation decisions. This should include the effect on employment and knock-on effects on the local/regional economy, direct or indirect public subsidies and grants, the cost of retained risks and the potential cost of contract variations. It should also include the failure to achieve savings targets, bringing some or all services in-house and other termination costs.
- Economic, social and environmental impact assessments (including sustainability appraisals) should be carried out for the procurement of services, development and infrastructure projects.
- Equality impact assessments should include the direct impact on service users and staff and the wider community and local economy.
- NHS Trusts and other health and social care organisations should strive to maximise the local or regional sourcing of goods and services. It should be part of strategic procurement policies and supported by regular sample audits of the sourcing of particular goods and services.

Tackling inequalities

- It is strongly recommended that a social justice approach should be adopted in further analysis of the health and social care economy in the North West.
- The provision of adequate and affordable social and key worker housing in close proximity to major health and social care facilities is essential and should be a key component of local plans, development proposals and Section 106 agreements with developers.

Democratising health and social care

- The formation of new NHS and local authority owned/controlled health and social care organisations, joint ventures and partnerships in the region must be democratically accountable and transparent. It should involve staff and service users and be subject to regular monitoring and review.
- NHS organisations and local authorities should take immediate steps to involve staff and trade unions in the reconfiguration process and to draw on their ideas, experience and innovation.
- NHS Trusts should be represented on Health and Wellbeing Boards which should a duty to increase the democratisation and participation in the health and social care economy.

Transparency

- Freedom of Information requirements must be extended as a matter of urgency to private, non-profit and voluntary sector companies and organisations providing public services.

- Private health sector data collection must be re-instated together with regularly updated information on the private health and social care sector including all categories of nursing and care homes, social care services, Any Qualified Provider contracts and NHS contracts.

- CCGs should be required to fully cost and disclose every options appraisal, procurement and market making activity. This should include identifying transaction costs including internal staff time and resources, consultants, market analysis and the cost of managing and monitoring contracts.

Maximising the regional benefits of a growing health and social care economy

The North West has the Liverpool and Greater Manchester City Regions; it has 13% of the population of England; the North West region is one of the UK's leading biomedical research centres, a centre of pharmaceutical production and Europe's largest cluster of advanced flexible materials manufacturers. However, it has high levels of deprivation, together with health and economic inequalities and has suffered deep austerity public spending cuts in local government services. It is, therefore, essential to maximise the benefits of the region's health and social care economy to improve services, increase good quality jobs and generate sustainable growth.

Appendix 1 Methodology for health and social care economy analysis

Appendix 2 Tables

Table 45: **Outsourced NHS facilities management contracts in North West 2013-2014**

Organisation name	Organisation Type	% of hard FM (estates) & soft FM contracted out	Annual value of contracted out services (£)
Southport & Ormskirk Hospital NHS Trust	Acute - Small	19.00	2,800,772
Sefton			
Aintree University Hospital NHS Foundation Trust	Acute - Medium	23.90	3,833,950
Alder Hey Childrens NHS Foundation Trust	Acute - Specialist	14.60	2,394,465
Clatterbridge Cencer Centre NHS Foundation Trust	Acute - Specialist	0.00	
Liverpool Heart and Chest NHS Foundation Trust	Acute - Specialist	18.17	2,919,605
Liverpool Women's NHS Foundation Trust	Acute - Specialist	58.00	2,666,000
Liverpool Community Health NHS Trust	Community	56.10	5,770,274
Mersey Care NHS Trust	Mental Health & Learning Disability	13.39	4,439,508
Royal Liverpool & Broadgreen University Hospitals NHS Trust	Acute - Teaching	57.07	28,339,570
St Helens and Knowsley Teaching Hospitals NHS Trust	Acute - Medium	67.0	17,893,869
Walton Centre NHS Foundation Trust	Acute - Specialist	39.75	3,258,877
Wirral University Teaching Hospital	Acute - Teaching	28.0	1,597,982
Wirral Community NHS Trust	Community	16.94	393,178
Sub total: Liverpool City Region			**76,308,050**
Bolton NHS Foundation Trust	Acute - Medium	49.00	6,251,759
Bridgewater Community Healthcare NHS Trust	Community services	95.00	2,159,736
Central Manchester University Hospitals NHS Foundation Trust	Acute - Teaching	64.11	36,163,969
Greater Manchester West Mental Health NHS Foundation Trust	Mental Health & Learning Disability	25.76	1,252,906
Manchester Mental Health & Social Care Trust	Care Trust	100.00	5,754,111
Pennine Acute Hospitals NHS Trust	Acute - Large	39.18	17,871,517
Pennine Care NHS Foundation Trust	Mental Health & Learning Disability	35.00	1,980,000
Salford Royal NHS Foundation Trust	Acute - Teaching	34.68	3,733,456
Stockport NHS Foundation Trust	Acute - Medium	5.59	1,432,437
Tameside Hospital NHS Foundation Trust	Acute - Small	54.00	8,484,830
The Christie NHS Foundation Trust, Manchester	Acute - Specialist	25.05	6,663,540
University Hospital of South Manchester NHS Foundation Trust	Acute - Teaching	50.50	22,743,143
Wrightington, Wigan & Leigh NHS Foundation Trust	Acute - Medium	12.30	3,133,817
Sub total: Greater Manchester City Region			**117,625,221**
Blackpool Teaching Hospitals NHS Foundation Trust	Acute - Medium	19.94	7,341,878
Calderstones Partnership NHS Foundation Trust	Mental Health & Learning Disability	31.50	4,273,940
Cheshire & Wirral Partnership NHS Foundation Trust	Mental Health & Learning Disability	14.00	1,836,059
Countess of Chester Hospital NHS Foundation Trust	Acute - Small	10.40	1,772,353
Cumbria Partnership NHS Foundation Trust	Mental Health & Learning Disability	11.27	1,607,363
East Cheshire NHS Trust	Acute - Small	55.43	7,605,432
East Lancashire Hospitals NHS Trust	Acute - Large	10.30	5,201,213
Five Boroughs Partnership NHS Foundation Trust	Mental Health & Learning Disability	17.00	1,784,960
Lancashire Teaching Hospitals NHS Foundation Trust	Acute - Teaching	24.00	11,755,265
Lancashire Care NHS Foundation Trust	Mental Health & Learning Disability	27.50	8,431,621
North Cumbria University Hospitals NHS Trust	Acute - Medium	44.41	9,568,741
North West Ambulance Service NHS Trust	Ambulance Trust	94.00	6,824,317
The Mid Cheshire Hospitals NHS Foundation Trust	Acute - Small	17.35	2,463,852
Warrington & Halton Hospitals NHS Foundation Trust	Acute - Small	10.88	2,564,941
University Hospitals of Morcambe Bay NHS Foundation Trust	Acute - Medium	8.04	1,613,865
Sub total: Cumbria, Lancashire & Cheshire areas			**74,645,800**
Total			**268,579,071**

Source: Hospital Estates and Facilities Statistics, Health and Social Care Information Centre, 2014f,

Table 46: **Directly employed staff employed in NHS facilities management services**

NHS Trusts	No of staff employed in soft FM support services (FTE)
Southport & Ormskirk Hospital NHS Trust	258
Sefton	**258***
Aintree University Hospital NHS Foundation Trust	552
Alder Hey Childrens NHS Foundation Trust	145
Clatterbridge Cancer Centre NHS Foundation Trust	51
Liverpool Heart and Chest NHS Foundation Trust	112
Liverpool Women's NHS Foundation Trust	12
Liverpool Community Health NHS Trust	3
Mersey Care NHS Trust	310
Royal Liverpool & Broadgreen University Hospitals NHS Trust	541
St Helens and Knowsley Teaching Hospitals NHS Trust	537
Walton Centre NHS Foundation Trust	99
Wirral University Teaching Hospital	485
Wirral Community NHS Trust	3
Sub total - Liverpool City Region	**3,108**
Bolton NHS Foundation Trust	283
Bridgewater Community Healthcare NHS Trust	36
Central Manchester University Hospitals NHS Foundation Trust	598
Greater Manchester West Mental Health NHS Foundation Trust	103
Manchester Mental Health & Social Care Trust	1
Pennine Acute Hospitals NHS Trust	943
Pennine Care NHS Foundation Trust	121
Salford Royal NHS Foundation Trust	299
Stockport NHS Foundation Trust	372
Tameside Hospital NHS Foundation Trust	214
The Christie NHS Foundation Trust, Manchester	213
University Hospital of South Manchester NHS Foundation Trust	437
Wrightington, Wigan & Leigh NHS Foundation Trust	432
Sub total - Greater Manchester City Region	**4,052**
Blackpool Teaching Hospitals NHS Foundation Trust	268
Calderstones Partnership NHS Foundation Trust	44
Cheshire & Wirral Partnership NHS Foundation Trust	175
Countess of Chester Hospital NHS Foundation Trust	252
Cumbria Partnership NHS Foundation Trust	113
East Cheshire NHS Trust	124
East Lancashire Hospitals NHS Trust	582
Five Boroughs Partnership NHS Foundation Trust	88
Lancashire Teaching Hospitals NHS Foundation Trust	533
Lancashire Care NHS Foundation Trust	152
North Cumbria University Hospitals NHS Trust	156
North West Ambulance Service NHS Trust	78
The Mid Cheshire Hospitals NHS Foundation Trust	323
Warrington & Halton Hospitals NHS Foundation Trust	243
University Hospitals of Morcambe Bay NHS Foundation Trust	378
Sub total - Other North West NHS	**3,509**
Total	**10,669**

Source: HSCIC Hospital Estates and Facilities Statistics, 2014. * Sefton included in Liverpool City Region total

Table 47: **Sale of equity in PFI healthcare projects in the North West**

Date	Vendor	Project	Purchaser	% holding sold	Price £m	Profit £m	Annual Rate of Return
23/11/05	Alfred McAlpine plc	Wythenshaw Hospital, University Hospital of South Manchester NHS Foundation Trust	Secondary Market Infrastructure Fund (now Semperian PPP Investment)	25.0	7.5	4.3	18.1
29/11/05	WS Atkins plc	Wythenshaw Hospital, University Hospital of South Manchester NHS Foundation Trust	Secondary Market Infrastructure Fund (now Semperian PPP Investment)	25.0	7.8	5.7	36.6
29/03/06	HSBC	Royal Blackburn Hospital	HSBC Infrastructure Company Limited (HICL)	50.0	n/a	n/a	n/a
04/05/06	Lend Lease Corporation & Bank of Scotland	Burnley Hospital	Lend Lease joint venture with Bank of Scotland (incl project in Republic of Ireland)	n/a	n/a	n/a	n/a
01/07/07	William Pears Group and Capital & Provident Regeneration	St Helens, Knowsley, Halton & Warrington LIFT	Fulcrum Infrastructure Group Holdings (Meridiam Infrastructure Finance, Luxembourg)	n/a	n/a	n/a	n/a
12/07/07	Amec plc	Cumberland Infirmary	Land Securities Trillium (now Semperian PPP)	50.0	n/a	n/a	n/a
01/03/09	Taylor Woodrow Construction (Vinci)	St Helens & Knowsley Hospital	Innisfree Ltd	30.0	n/a	n/a	n/a
10/12/10	Lend Lease Corporation	Burnley Hospital, East Lancashire Hospitals NHS Trust	Lend Lease Infrastructure Fund joint venture with PGGM (Dutch pension administrator)	n/a	n/a	n/a	n/a
04/10/11	Lend Lease Corporation	Central Manchester University Hospital	Lend Lease UK Infrastructure Fund - 90% owned by PGGM	50.0	30.0	n/a	n/a
01/10/11	John Laing (Henderson Global Investors)	Manchester, Salford and Trafford LIFT	Equitix Ltd and Community Solutions	n/a	n/a	n/a	n/a
10/11/11	Balfour Beatty plc	Royal Blackburn Hospital (Consort Healthcare Blackburn (Holdings) Ltd)	HICL Infrastructure Company	50.0	12.0	6.0	12.0
29/03/12	Bilfinger Berger	Liverpool & Sefton Clinics (LIFT Tranche 1a)	Bilfinger Berger Global Infrastructure	26.7	n/a	n/a	n/a
09/07/12	Eric Wright Group	Whitegate Drive Health Centre, Blackpool	HICL Infrastructure Company (75%) via JVC Kajima Partnerships (25%)	100.0	2.9	n/a	n/a
23/07/12	Barclays Infrastructure Fund ll	Bury Tameside & Glossop LIFT project	Equitix Ltd	50.0	n/a	n/a	n/a
01/03/13	Morgan Sindall plc	Wigan Joint Services Centre	Equitix Ltd	50.0	n/a	n/a	n/a
01/05/13	Balfour Beatty plc	Tameside Hospital	HICL Infrastructure	50.0	16.0	9.0	22.7
01/07/13	Balfour Beatty plc	Salford Hospital	HICL Infrastructure	50.0	22.0	11.5	18.8
23/12/13	Bilfinger Group	Mersey Care Mental Health Hospital	Bilfinger Berger Global Infrastructure	24.5	n/a	n/a	n/a
14/02/14	Assura Group Ltd, Warrington	Mersey Care Mental Health Hospital	Bilfinger Berger Global Infrastructure	28.6	n/a	n/a	n/a
14/02/14	Assura Group Ltd, Warrington	Liverpool & Sefton Clinic LIFT	Bilfinger Berger Global Infrastructure	20.0	n/a	n/a	n/a
07/04/14	Galiford Try plc	Liverpool & Sefton Clinic LIFT	Bilfinger Berger Global Infrastructure	6.67	n/a	n/a	n/a
24/07/14	GB Partnerships Ltd	Mersey Care Mental Health Hospital	Bilfinger Berger Global Infrastructure	12.5	n/a	n/a	n/a

Source: PPP Equity Database, European Services Strategy Unit, 2012.

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