Health Campaigns Together

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VOTE to save the NHS – not for five more years of CUTS!

Jess Hurd/reportdigital.co.uk

250,000 protestors from all over England poured in to London on March 4 to demand an end to cuts, closures, and privatisation of #ourNHS

#voteNHS

A poll in the *Independent* on April 24 showed the NHS was the leading concern in the eyes of the public, ahead of Brexit and other issues that ministers are keen to focus on, with 70% of those asked putting the NHS as their number one issue.

After ten years of increased NHS spending to 2010, we have had seven years of real terms NHS funding falling ever further behind rising population and cost pressures, and after last winter's widely reported crisis of beds and delayed discharges it's obvious why.

We are in the midst of what is planned to be least a decade of virtual freeze on NHS budgets – aiming to reduce the share of GDP spent on health: spending per head is set to fall.

Meanwhile spending on social care, which is supposed to be developed to support vulnerable people outside hospital, has been slashed – by an average of 11% per person since 2010 according to the IFS. Cuts in social care have been the deepest in the areas of greatest need: these cuts have impacted on hospital care:

- a lengthening queue of almost 4 million people waiting for an operation; more waiting beyond the 18 week maximum established in the NHS Constitution.
- emergency patients left waiting hours on trolleys for lack of beds, because there is no social care for patients outside hospital.
- over 200,000 people waiting over 4 hours in A&E in February
- mental health patients being transported across the country in search of beds, or winding up in police cells or prison for lack of care.
- despite closing over 9,000 acute beds since 2010, desperate health chiefs are drawing up plans in many areas for further cuts and closures. Many could lose local access and face journeys of 50 miles or more to hospital.

NHS Providers, representing trust managers, has described the financial squeeze over the next five years as "Mission Impossible". The Care Quality Commission has warned that the NHS is on a "burning platform".

Sir Robert Francis, who led the inquiry into the Mid Staffordshire Hospitals scandal a decade ago, warns the NHS faces an "existential crisis".

These are not party political points: these are the brute facts. **That's why Health Campaigns Together, affiliated to no party, urges voters in every area to back only candidates who show themselves willing to stand up for local access to services, proper funding of the NHS, and who are prepared to fight on against cuts and closures after June 8.**

Promised '£10bn extra for the NHS' was never real

The government claim to be injecting an "extra £10 billion" to the NHS by 2020 is now widely discredited.

The numbers have perhaps been best explained by the Nuffield Trust's Sally Gainsbury.

She shows that the £8 billion from 2016-2020-21 began at best as a rounding up of an actual £7.6 billion uplift over 5 years. It was only inflated to the mythical £10 billion figure by adding in the money already allocated for the previous year 2015-16.

But it was always a deception: because while alongside some increases to NHS England's budget, there are simultaneous *cuts* of over £3 billion being imposed on the rest of the Department of Health budget, which is not ring-fenced against cuts.

So £7.6bn from 2016-2020 turns out to be just £4.5bn extra health spending over the same 5 years.

However the £4.5bn "real terms" increase is itself calculated on the basis of general inflation in the economy, not the much higher levels of price increases faced by the NHS in the global market for drugs and equipment.

These threaten cost increases high enough to wipe out another £3.7 bn.

In other words the promised £10 bn "real terms" increase is actually worth

less than a tenth of that amount, just £800 million, over the next few years to 2020.

And the comparatively generous financial uplift of 2016-17 is followed by two more years of even more brutal squeeze on spending, which is set to force a massive round of further cuts and desperate so-called "savings."

These will put local access to hospitals and other health services at risk for millions, most of them older and living in more rural areas.

Devon MP Sarah Wollaston, Chair of the Commons Health Committee, was among the growing ranks of those who openly criticised the government's deception.

Cuts kill: research points to death toll

Independent research has now shown that failures in the health and social care system linked to disinvestment are likely to be the main cause of a substantial increase in mortality in England and Wales in 2015.

There were 30,000 excess deaths in 2015, representing the largest increase in deaths in the post-war period. The excess deaths were largely in the older population who are most dependent on health and social care.

The researchers from the London School of Hygiene & Tropical Medicine, University of Oxford and Blackburn with Darwen Borough Council, tested four possible explanations for a January 2015 spike in mortality.

After ruling out data errors, cold weather and flu as main causes for the spike, the researchers found that NHS performance data revealed clear evidence of health system failures.

Almost all targets were missed including ambulance call-out times and A&E waiting times, despite unexceptional A&E attendances compared to the same month in previous years. Staff absence rates rose and more posts remained empty as staff had not been appointed.

Professor Martin McKee, from the London School of Hygiene & Tropical Medicine, said: "The impact of cuts resulting from the imposition of austerity on the NHS has been profound.

"Expenditure has failed to keep pace with demand and the situation has been exacerbated by dramatic reductions in the welfare budget of £16.7 billion and in social care spending."

'Is your body actually two write-offs welded together?'

He added: "With an aging population, the NHS is ever more dependent on a well-functioning social care system. Yet social care has also faced severe cuts, with a 17% decrease in spending for older people since 2009, while the number of people aged 85 years and over has increased by 9%."

"Given the relentless nature of the cuts, and potential link to rising mortality, we ask why is the search for a cause not being pursued with more urgency?"The researchers say that there are already worrying signs of an increase in mortality in 2016. Without urgent intervention, they say, there must be concern that this trend will continue.

On 1 April 1,200 learning disability service staff previously employed by Somerset county council were transferred to Discovery, a social enterprise sub-division of Dimensions UK. While it may not run for profit, Discovery runs as a business, and its pay scales are much lower: a relief workers on a shift pattern of 30 hrs per week working 4 hrs over the weekend is set to lose over £1800 per year, or about 13% of their income

Fears that social care 'beginning to collapse'

NHS England hopes to work "closely with community services and councils, hospitals need to be able to free up 2,000-3,000 hospital beds."

It has published target numbers of beds it would like to see 'freed up' in each area, allowing the discharge of older patients to some form of social care.

This optimistically assumes local authorities will spend all or most of the additional social care funding given to them in the 2017 budget to relieve the pressure on the NHS, by increasing the provision of nursing home places and domiciliary care to support patients in their own homes.

Other analysts such as the Nuffield Trust warn that given the mounting crisis in social care there are questions over whether anything like this level of relief can be delivered.

The facts would indeed suggest otherwise. New figures from the IFS show the extent of actual cuts in social care that have already been imposed by councils whose core funding has been cut by 37% since 2010, with further cuts due each year to 2020.

Overall spending fell by 11% to 2015, but one in ten councils made cuts of over 25%, while of course even more cuts have followed in 2016/17.

The BBC has reported a letter from the chairman of the UK Homecare Association to the Prime Minister warning that with a constantly changing and discontented, underpaid workforce, the adult social care system has "begun to collapse".

A Commons Communities and Local Government Committee report has also warned of the instability and pressures on under-funded and financially precarious care homes and services, raising serious doubts over their ability to play the role required of them by NHS England and local Sustainability and Transformation Plans.

Many care homes clearly fail on a number of levels, not least in the lack of adequate nurse staffing and proper clinical support from GPs.

Staffing is a major issue. Up to half of the care workforce are on zero hours contracts, with pay levels averaging close to the minimum wage and around half the national median annual earnings.

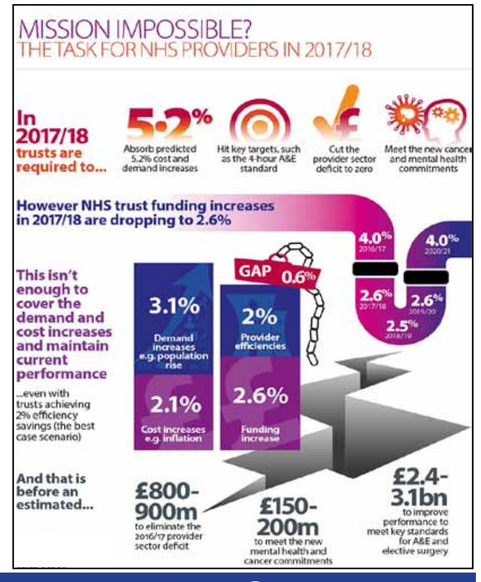
These poor employment conditions make it even harder to recruit and retain staff, leaving the sector heavily dependent on an estimated 60,000 staff from other EU countries and overseas – with an IPPR report raising even more questions over the long term viability of social care services as Brexit looms.

84,000
Latest number of social care jobs vacant

48%
of social care staff leave within a year of starting

4/5 GPs hit social care problems

A survey for ***GPonline*** magazine found four out of five GPs reporting that social care cuts have been driving up the workload on their practices in the last year, including delays in social care assessments, problems finding respite care, and patients who could be supported at home having to be sent to hospital for lack of adequate social care alternatives.



Media must prevent ministers from hiding key data from voters

From news reports by both ITN and BBC it's clear that ministers are now working behind the scenes to seek ways to delay or restrict the publication of embarrassing official statistics on the state of the NHS.

NHS England's monthly performance figures, which have appeared regularly since 2015, are due to be published on May 11 – and again on Polling Day, June 8 itself, a day which would not normally feature any election debate. These statistics are not covered by the conventional "purdah" period of restrictions on official policy announcements by public bodies; but they could make a last minute impact on voters.

There is every reason to believe the figures will tell another grim story of the continuing decline of NHS performance, and pressure on front line services. In addition another body, NHS Improvement, the regulator, is also due to publish updated figures on trust deficits, which will also reveal the full extent of last year's financial problems, two weeks or so before the election.

It's already clear ministers are desperately seeking ways to keep any real debate over the state of the NHS out of the election period; will they be allowed by the media to gag the official bodies that are supposed to be reporting to the public?

Bed numbers slashed since 2010

In 2010 when David Cameron won the General Election there were 144,500 beds in England's NHS: six years later 15,000 of these had closed – leaving a total of 129,500.

But the pace of closure has also been rapid in the "general and acute" beds which treat emergency admissions, waiting list cases and also include any remaining beds for older patients.

In 2010 there were 110,568 of these: six years later there were just 101,589, a loss of close to 9,000 front-line beds, while the population has increased: no wonder the remaining beds were full to overflowing last winter!

The reduction has been even more spectacular in mental health, where numbers have been slashed from 23,500 in 2010 to just 18,800, a reduction of 4,700 (20%).

This explains widespread problems finding mental health beds, despite

20%
of **mental health** beds closed since 2010

9,000
acute beds closed

the rhetoric of parity of esteem for mental health needs.

The biggest cut of all has been in Learning Disabilities, where 50% of the already reduced 2010 NHS provision of beds has been axed in the last few years, with responsibility transferred to hard-pressed and under-funded social care – leaving many patients with health needs unable to access specialist support, and dependent on general NHS services.

Real NHS spend set to fall

NHS England chief executive Simon Stevens has insisted that real terms spending per head is set to go **DOWN** in 2018-19 and 2019-20.
It is due to fall from its current level of **£2,223** a head this year, dropping by **£16** next year and **£7** in 2019, while costs continue to rise.

UK spending less per head than comparable countries

(2015 figures from OECD, health spending per capita, figures all in **US$** purchasing power parities)

=UK +33.5%	Netherlands **5,343**
=UK +31.6%	Germany **5,267**
=UK +30.1%	Sweden **5,228**
=UK +10.1%	France **4,407**
	United Kingdom **4,003**

Latest Carter plan: axe community hospitals

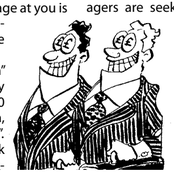
Lord Carter, the Labour peer brought in by the Tory government as an advisor on efficiency, has urged a sell-off of community hospitals where unit costs are high, so save revenue and raise capital.

He told a conference in April: "On property in community trusts one thing that jumps off the page at you is the very high cost of community hospitals because many are too small."

"Time and time again" his team found community hospitals costing £100,000 per bed year to keep open, which "isn't going to work".

Carter went on to talk favourably of the "remarkably effective estates rationalisation programme" of the US army whose "secret was… 'the wrecking ball'". As soon as property was designated as surplus, it would be demolished to avoid maintenance and security costs – but also end any further debate.

By contrast where local NHS managers are seeking to close community hospital beds, arguing they are inefficient to run, it is often controversial, and in some areas there are concerns about reducing the overall number of beds amid huge pressure on capacity.



NHS trusts want an extra £25 bn

NHS Providers, the organisation representing NHS trusts and foundation trusts, is issuing its own manifesto calling on all parties to **end the austerity funding** of the health service, and inject an extra **£5 billion a year** to 2020, as well as **£10bn in capital** to pay for backlog maintenance and upgrading of buildings and equipment.

Bottom of the league!

According to the latest figures from the Organisation of Economic Cooperation and development (OECD) monitoring 35 wealthier countries, the virtual freeze on UK health spending since 2010 has brought us near the bottom in comparison of access to key resources for modern health care.

The UK is 29th of 35 on provision of doctors per 1,000 population (**2.8 in the UK, compared with an OECD average of 3.3**).

The UK is 30th of 32 on provision of **CT scanners**, with just **8** scannners per million population, compared to an OECD average of **25.3**. **Only Mexico and Hungary have fewer per head.**

The UK is 33rd of 35 on provision of **acute hospital beds** (UK **2.3** per 1,000 population, OECD average **3.6**). **Only Chile and Mexico had lower provision.**

The UK is 29th of 31 on provision of **MRI scanners** (**6.1** per million population UK, OECD average **14.9**). **This puts us lower than Turkey 9.8: only Mexico, Hungary and Israel have fewer.**

Sustainability and Transformation Plans

The case of the missing evidence

During 2016 England's NHS was redivided into 44 strategic "footprint" areas, each of which was required to draw up a Sustainability and Transformation Plan" (STP).

The STPs were required to address the "triple challenge" of improving public health, improving the quality of health care and bridging the "affordability gap" by generating savings towards the £22 billion projected shortfall by 2020/21.

The generally weak – and in many cases almost complete lack of – evidence to support some of the key proposals in the 44 STPs reflects their origins in the largely speculative *Five Year Forward View* **adopted by NHS England in 2014 , which has been updated in March 2017 in the document** *Next Steps on the NHS Five Year Forward View*.

The Executive Summary of *Next Steps* **gives an overview which presents a completely one-sided assessment of the current situation and short term future of the NHS, focused entirely on the "good news" and future aspirations.**

It largely ignores all of the concrete problems that have been highlighted in the actual developments in the last 12 months.

In the coming election parties need to address the future of the NHS and the extent to which the plans and policies are based on evidence. Here we raise some of the sharp questions the STPs avoid.

Rural areas face lengthening journeys

Despite ostensibly seeking to address local health inequalities, not one of the STPs refers to an Equalities Impact Analysis or appears to have made any assessment of the impact of their changes – especially when it comes to people living in rural areas.

In many parts of the country STPs and other plans to centralise or consolidate services result in patients and potential patients, who may be older, of limited mobility, lacking access to a car, on low incomes and with no family members close by, facing potential journeys of up to 50 miles on poor country roads to access hospital care.

Only one of the STPs recognises these issues: Lincolnshire, which reveals itself uniquely sensitive to the objective situation, and somewhat at variance with the drive towards reconfiguration, notes "travel times between towns and villages being relatively high," and that as a result, "All site reconfiguration scenarios will be modelled in terms of understanding the impact on emergency transport, patient transport, voluntary and private transport…" (p103).

STPs themselves also extending the geographical spread in many cases from CCG level to much wider areas and populations. In some areas CCGs are planning mergers that would cover large and diverse communities.

While local authorities may retain powers of oversight and scrutiny on changes in NHS services, and Health and Wellbeing Boards may have some potential influence over public health issues, there is a danger that as the size of geographic spread expands, NHS commissioners will become less accountable to the needs and wishes of specific local communities.

This seems to coincide with what Simon Stevens wanted to achieve in establishing STPs: to overcome 'veto power'. But it is also one of the reasons that plans such as Staffordshire and Stoke-on-Trent, Devon, and Lincolnshire, that appear to the communities who face losing local access to services as riding roughshod over local needs and views, have become controversial as soon as they have reached the public arena.

In short STPs are already showing themselves in practice to be far from the friendly, strategic, common-sense 'place-based' plans that they are purported to be, and their potential as extra-legal bodies to override the voices and views of local communities, statutory NHS bodies and even elected local district councils is a predictable basis for controversy.

In denial on GP crisis

NHS England sees increased numbers of GP appointments as one of the ways to divert thousands of patients from over-stretched A&E services, with promises that in addition to urgent cases, routine patients will also be able to get "a convenient and timely appointment with a GP" when they need one:

This is simply wishful thinking. Despite the warm words of last year's *General Practice Forward View*, resources and staffing in primary care are still inadequate to deal with rising demand and increased responsibilities allocated by NHS England.

The *Next Steps* claims: "We have begun to reverse the historic decline in funding for primary care, and over the next two years are on track to deliver 3,250 GP recruits, with an extra 1,300 clinical pharmacists and 1,500 more mental health therapists working alongside them."

By contrast the *Daily Telegraph* reports *Pulse* magazine figures showing record numbers of GP practices closing, with closures increased by numbers of GPs retiring ahead of new tax burdens on pension pots. Far from increasing, *Pulse* says the total number of GPs fell by 400 in the last year.

3,250
target for increase in GP numbers in England by 2020

400
fall in numbers of GPs last year

London GPs warned over fake models of care

London GPs' leader Dr Michelle Drage has called for an end to 'fake models of care' which divert resources from the front line, and urged GPs to lead service transformation on their own terms.

'New models of care, led by political imperatives rather than evidence, are pushed by the stick of contract changes and the carrot of funding streams,' she said.

"The ambition of providing "care at scale" results in the at-scale part taking up all the resource and the providing care part coming in second place. We cannot have that.'

"So let's stop faffing around creating models of care. Plans in the sky just drive more plans."

GPs divided over primary care "at scale"

Some GP practice closures are linked to the process of mergers into "supersurgeries" and "hubs" as part of the *Forward View*.

MPs have been told the new model could reduce general practice in England from 7,500 practices to just 1,500, covering lists of 35-40,000 patients.

However 4 out of every 5 GPs in a *GPonline* survey expressed concerns that this idea of "primary care at scale" would undermine general practice, with just 5% saying it would improve GP services.

More than half of the respondents in the *GPonline* survey said they would not be willing to work in a superhub.

The bigger units fly in the face of evidence that primary care is most effective where continuity of care is established and maintained between patient and GP.

Millions of people lost on digital highway

Every STP is required to develop its own "Digital Road Map" and strategy to make use of new technology to enhance efficiency in delivery of health care and open up new possibilities for patients to take control of aspects of their own health.

But little evidence is offered on the cost-effectiveness of such technology, which has been only slowly rolled out even in the USA, and remains largely untested in the NHS.

A report on this by the Nuffield Trust at the end of 2016 echoes the concerns of many critics of the drive for digital health care, but also seems to endorse NHS England's disregard for some of the actual problems, not least that some of the heaviest users of health care, especially those in long term poverty, and the frail elderly, are often left out by digital initiatives:

"Over 12 million people in the UK lack basic digital skills. This group is made up of people vulnerable to social exclusion: 60 per cent have no qualifications, 57 per cent are over 65 years old and 49 per cent are disabled.

"Recent figures show that almost two-thirds of people aged over 75 and a third of 65- to 74-year-olds say they do not use the internet at all, compared with 17 per cent of 55- to 64-year-olds and 5 per cent or less of people aged under 55.

"There is also a relatively high 'drop-out rate' of internet use among the older population. Reasons for older people's disengagement from internet use include: a lack of skills and knowledge of the internet, a feeling that the internet is not useful to them, cost, disability, social isolation, and concern that the internet could take away social interactions."

Some of these problems are pretty major obstacles to significant groups of NHS patients accessing digital services (not least the cost of broadband connections for those on extremely low incomes).

In addition the blog promoting the report concedes: "Recent studies suggest 60 per cent of working-age people in the UK find health information containing both words and numbers too complex.

"Some people also struggle to identify trusted sources of online information. Millions of people in the UK are still offline or lack basic digital skills.

"Many of these are the people at most risk of social exclusion, such as those aged 65 and over, the unemployed and people with disabilities."

Another factor which may give pause for thought among those seeking cost savings through the use of new technology is the finding of a 2012 US study that "having online access to medical records and clinicians was associated with increased use of clinical services compared with group members who did not have access".

Nor is there much indication of surging public demand for more digital links.

In November 2016, HSJ revealed that while 97 percent of patients were served by GP practices offering digital bookings, just 4% of GP appointments were booked online.

12 million
the number of people in the UK who **"lack basic digital skills"**

57%
the proportion of these who are **over 65**

60%
of **working-age** people in the UK find health information containing both words and numbers **too complex**

Experts slam "ridiculous" A&E cuts

Leaders of the Royal College of Emergency Medicine have been speaking out over plans in STPs for the downgrading or closure of A&E units, and a resulting loss of beds are resources.

Dr Chris Moulton, vice president of the (RCEM), told the i newspaper in February of his concerns that the plans are not based on evidence.

"A&E units are already desperately short of capacity and hospitals have almost 100 per cent bed occupancy. The suggestion that you can close A&E departments and then somehow fewer people will become ill is clearly ridiculous.

"Anyway, it's not people with minor illnesses but elderly patients with serious conditions who are the ones lying on A&E trolleys waiting for beds and then languishing on the wards awaiting social care.

"The problem is that the STPs are trying to design the health service around the fallacy that you can downgrade A&E departments and then not provide comparable capacity elsewhere.

"They are predicting a pattern of falling demand when A&E attendances have consistently risen for decades.

"There is no clear indication as to how this miracle might be achieved.

"We have a rapidly growing and ageing population and therefore the idea that the health service won't have to deal with even higher numbers of people requiring emergency care and hospital admission in the future is like hoping that the River Nile will run backwards."

Dr Taj Hassan, RCEM president, added "If one in six emergency departments are downgraded, the effects would be disastrous.

"Closure of any emergency department will naturally require more beds to be found elsewhere – patients do not just disappear."

530
target for bed cuts in **Derbyshire's** STP

202
community hospital beds to close in Herefordshire & Worcestershire

118
acute beds to close in **Lincolnshire**

296
acute beds to close in **Kent and Medway**

360
bed cuts planned in **Dorset**

175
number of **emergency units** in England's NHS

24
of these could face **downgrade or closure** from plans in STPs

6%-30%
range of targets in many STPs for **reducing** attendances at A&E services

12.2%
actual **increase** in A&E attendances January-March 2016 compared with Jan-March 2015

What do your local candidates say? Make them answer on the NHS!

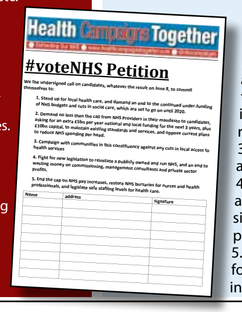
Health Campaigns Together is circulating printed copies of a petition that can be used in any part of the country by campaign groups, 38 Degrees, trade unions, Facebook, Twitter, door-to-door canvassers for political parties, street stalls, neighbourhood groups, people emailing their friends with the link, etc.

People should be asked to sign their support for the NHS – but should also be urged to press the candidate they vote for to declare their full support for the NHS.

In hustings and other events, candidates should each be challenged to state clearly where they stand, allowing voters to #voteNHS, backing only those candidates who are prepared to fight for local services.

We can publish the results on websites, press releases, billboards, flyers. The response of local candidates to this petition will be made available to the public in local constituencies and will be made available on HCT website, and social media including the NHS Roadshow.

This campaign is not aligned with any political party, but it will allow campaigners to publicly shame candidates who refuse to sign their support for the NHS.


Health Campaigns Together
#voteNHS Petition
We the undersigned call on candidates, whatever the result on June 8, to commit themselves to:
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2. Demand no less than the call from NHS Providers for an extra £5bn per year national and local funding for the next 3 years, plus £10bn capital, to maintain existing standards and services, and oppose current plans to reduce NHS spending per head.
3. Campaign with communities in this constituency against any cuts in local access to health services
4. Fight for new legislation to reinstate a publicly owned and run NHS, and an end to wasting money on commissioning, management consultants and private sector profits.
5. End the cap on NHS pay increases, restore NHS bursaries for nurses and health professionals, and legislate safe staffing levels for health care.
Name | address | signature

#voteNHS Petition

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Campaign hots up to defend King George's hospital

Hundreds of local people joined a demonstration on Saturday 18th March in Ilford, London, to protest against the closure of the local A&E in King George hospital.

The march concluded with a packed rally in Ilford Town Hall, addressed by local faith leaders, councillors, and two Labour MPs – Mike Gapes and Wes Streeting.

The A&E closure – agreed several years ago – has been put on hold because of the pressures on the health service in North East London.

Both local acute trusts – Barts, and Barking, Havering and Redbridge University Trust (BHRUT) have big PFI debts and have been on special measures. Despite North East London having the largest population growth projected in London, and high levels of poverty and deprivation, the A&E closure has been included in the local STP plan.

Bed occupancy levels are dangerously high – over 90% in the first month of this year in Barts hospitals – and ambulance queues and diversions are regular occurrences.

And across the whole of North East London GP numbers are set to decline.

In Waltham Forest, Newham and Tower Hamlets GP numbers are expected to drop from 600 to 400 in 7 years, not including an extra 195 GPs needed because of population growth.

Redbridge and Barking and Dagenham will need an extra 106 and 56 GPs respectively by 2020 to cope with population growth and existing shortages. Yet the STP plans will proceed with the closure of the A&E at King George Hospital in 2019.

Campaigners and some local politicians are in no doubt that this will put local residents' health at risk and put already stretched and stressed health staff under impossible pressure. A further demonstration is planned for October to pressurise the Secretary of State for Health to review the closure decision.

Devon campaigners put politicians on the spot

Save Our Hospital Services Devon (SOHS) urges the public to make hospital services and social care a top priority when considering how to vote. Here are the facts:

The Wider Devon Sustainability and Transformation Plan (STP) will slash £550m from the county's health budget by 2020/21. In simple terms, that means cuts.

Across Devon, community hospitals have been decimated. The STP target was to close 190 community hospital beds. North Devon is now down to just 12 community hospital beds for a population of 170,000 people. South Devon is facing the closure of four hospitals. East Devon is losing half of all its in-patient beds.

A mind-boggling 400+ acute beds are being eliminated county-wide. That means beds at Derriford Hospital, Royal Devon and Exeter Hospital, Torbay Hospital and North Devon District Hospital.

In place of acute and community hospital beds, the new model of "care closer to home" continues to be rolled out even though it remains unproven and inadequately scrutinised.

North Devon District Hospital is facing the potential removal or downgrading of acute services including stroke, maternity, paediatrics, neonatology and urgent & emergency care.

Affected patients would have to travel up to two hours to receive vital treatment. Even one of the co-authors of the STP admits that people may die as a result!

It's a grim picture, but the upcoming elections represent a real opportunity to turn the tide.

Ultimately, health policy is driven by politicians, and it can only be changed by politicians pressurised from below.

SOHS passionately believes that the Devon public can make all the difference. The message is simple: however you vote, vote to save our hospital services!

http://www.sohs.org.uk/election.php

Saving money rather than babies' lives!

Gill George, Chair of Shropshire, Telford & Wrekin Defend Our NHS

The April Board meeting of Shrewsbury and Telford Hospital Trust (SaTH) was an illustration of what happens when spending cuts and a toxic culture come together.

Within their happy bubble, Board members discussed their progress on the journey to becoming an exemplar organisation – with astonishing detachment from the chaos that is engulfing core services at our hospitals in Shrewsbury and Telford.

They had something else to celebrate. They have successfully driven through cuts to reduce the deficit to £16.4 million. They congratulated themselves on that.

And there was one thing they refused point blank to discuss. This is the unfolding tragedy in their maternity services: the scandal of at least nine avoidable baby deaths since 2009, seven of these deaths between September 2014 and May 2016.

An NHS Improvement review is now looking at fifteen baby deaths and three maternal deaths. The Board was so desperate not to discuss baby deaths that they walked out of their own meeting (to cries of 'Shame on you' from the public).

1 in 3
of NHS trusts and health boards have temporarily **closed paediatric wards** due to staff shortages.

4 in 10
neonatal units have had to refuse new patients for lack of beds.

200+
unfilled vacancies for child health specialists across the NHS, including **133 consultants** (figures from Royal College of Paediatrics and Child Health)

When news of the deaths was broken by the BBC a few weeks ago, the response from SaTH was revealing. Medical Director Edwin Borman said that the rate of baby deaths at the trust was no worse than anywhere else in the NHS. You can sense the shrug of his shoulders as he spoke.

He missed the key point: that these deaths were avoidable. These are babies who did not need to die.

Mid-Staffordshire has never been more relevant – and there will be many more Mid-Staffordshires quietly brewing now, as spending cuts bite. Looking back at Mid-Staffs, three strands emerge with frightening clarity:

- A Board that was concentrating on cutting costs
- A Senior Management Team that stopped taking patient concerns seriously and stopped investigating those concerns robustly – so patient care was effectively downgraded
- And staff who felt unable to raise concerns about clinical safety – because they would either be ignored or victimised.

Those strands have come together at SaTH. The results have been catastrophic.

This isn't about individual midwives or doctors making mistakes. The failures in Shropshire are systemic. When a maternity unit lacks a crucial Operational Policy in 2009 and STILL lacks that policy in 2015, that's a management failure.

When essential training in neonatal resuscitation falls by the wayside, that's a management failure.

When staff shortages place women and babies at risk, that's about senior managers putting budgets before patient safety.

And above all, when avoidable deaths become normalised – that's a dreadful consequence of a Board that has lost its way. It is the Chief Executive and Medical Director who are culpable.

The culture in this Trust is toxic, yes, but the context is the biggest financial crisis the NHS has ever seen. The NHS is not overspent. It is underfunded.

The danger is that underfunding can lead to avoidable deaths being seen as collateral damage in the quest for perfect financial balance.

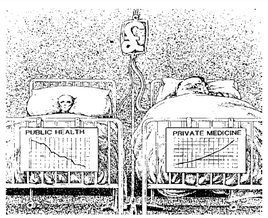
Private sector – a malignant growth

The NHS crisis since 2010 has been a historic opportunity for the private hospital sector – to fill large numbers of otherwise empty beds with patients paid for by the NHS, and to coin in increased profits.

Almost half of the additional £2bn of funding for the NHS commissioning budget in England in 2015/16 was spent on care provided by non-NHS providers.

Across England on average £1 in every £8 of local commissioners' budgets is now spent on care provided by non-NHS organisations.

In Mid Essex GPs have actually been urged by their local Clinical Commissioning Group to encourage their patients to go private, using health insurance if they have it.



Loss-making private hospital firm Circle, which tried and failed to run Hinchingbrooke Hospital, has been taken over by investment funds hoping that profits may flow from treating NHS patients.

NHS spending with Spire increased in 2016 to £293m, and is now almost a third of Spire's earnings, while NHS patients were almost 40% of Spire's admissions.

The NHS is filling what would otherwise be empty beds, because – even with an under-funded NHS facing highly publicised stresses and strains – the private health care "market" has failed to grow. Income from health insurance companies has fallen, although there has been a 9% increase in numbers of "self-pay" patients.

Spire's chain of small private hospitals does not carry the heavy costs of medical and nurse staffing that weigh down NHS acute hospitals. Nor do they treat any emergencies or complex elective cases. Spire provides only the simplest and least demanding elective treatment.

So Spire Healthcare's finance director is not bothered about a further 3.9% reduction in the NHS tariff rate this year, which will in theory lose Spire around £7m: even on the reduced payment there is still a profit for the private hospital chain from every NHS-funded patient they treat.

The same is true of other private hospital chains. Jill Watts, Chief Executive of the biggest British-based private hospital chain, South African-owned BMI, recently admitted to Healthcare Europa magazine that the company relies on NHS-funded patients for about 40% of what they do now, "and we've still got capacity."

BMI healthcare doubled its profits last year, with its NHS caseload up 13.5%. Profits have also been rising in Spire hospitals since the coalition took office in 2010.

Far from wanting to replace the NHS, the private sector sees it as a staple source of income. Looking ten years ahead, Ms Watts said BMI's best hope was for "a much stronger private sector which works in greater collaboration with the NHS and which offers a broader range of service."

NHS key principle broken by imposing charges

Charging 'foreign' patients puts us ALL at risk

Pregnant women seeking care from the NHS and patients first visiting a GP now need to take their passports with them as a result of new regulations that came into force in April: they require NHS staff to check the nationality of women giving birth at the hospital, and levy charges on any from overseas.

In order to duck charges of discrimination, the trusts could well have to check ALL pregnant women: and if this policy is rolled out it won't be long before all patients need to carry ID to prove that they are eligible for NHS treatment.

But it's even worse: guidance issued by Brighton and Sussex University Hospitals bosses makes clear that a passport in itself is not enough: "a person is not ordinarily resident in the UK simply because they have British nationality, hold a British passport; are registered with a GP; have an NHS number; own property in the UK; or have paid (or are currently paying) National Insurance contributions and taxes in the UK."

An additional proof of address has to be produced over and above the passport – and a maternity patients also needs to complete a pregnancy referral form. Any potential patients who cannot comply with all of these requirements can be required to pay a deposit up front or the full amount before they receive any treatment.

This is the nightmare that Nye Bevan warned against soon after the NHS was set up when some argued that "foreigners" should be forced to pay for services that from July 1948 had become the first in the world to be financed not through insurance but from general taxation, and provided free at point of use on the basis of clinical need.

To charge a relative handful of "foreigners," warned Bevan, would potentially inconvenience everybody, add more bureaucracy that would hold up the new efficient NHS – and possibly deter people from seeking medical help when they need it, and spread disease.

Right wing newspapers used the opportunity to trot out scare stories

of "organised illegal activity" shipping pregnant women into London to have their babies.

While those organising any such exploitation of the NHS should be dealt with by the police, the scale of the problem is tiny in proportion to the deficits imposed on the NHS by the freeze on budgets since 2010, and there is a real risk that people will be deterred from using A&E and other services and putting themselves – and unborn babies – at risk.

Royal College of Midwives leader Professor Cathy Warwick sounded a welcome note of common sense when she demanded assurances that

"all pregnant women who need care will receive it, no matter what their immigration status. The law says, and government policy says trusts must offer care to women in labour."

Up to May 2014, if you were a migrant living in the UK on a 'settled basis,' you were eligible for free NHS treatment, just like a UK citizen. The new Immigration Act changed all that, and makes healthcare access more restrictive in two main ways:

- Anyone from outside Europe who is lawfully applying to work or study here will be forced to pay an extra 'NHS surcharge' of up to £200 per year before they are given a visa
- Charging rules, which used to apply only to secondary care, will now be extended into primary care (GPs) and A&E departments.

The danger to us all is that when immigration enforcement enters the health service, many people will become scared and deterred from seeking care. Some migrants may not be sure of the healthcare access they are actually entitled to.

They may be afraid of having to pay or of having their movements reported to the Home Office and will not seek treatment.

Their health conditions will worsen and conditions that could have been more simply treated at an early stage will bring them to A&E at a much greater cost to the entire system (with an even smaller likelihood that they will be able to pay).

Since migrants will be treated differently than everyone else, NHS staff will now have to check the immigration status of everyone who uses the NHS whenever they register for a GP practice or go into A&E for emergency treatment.

A&E departments are already very busy and people often have long waiting times. If immigration status checks are forced upon overburdened A&E staff, delays will be more common and all patients will suffer by having to wait longer.

The NHS has never been a contribution or insurance-based system, and this surcharge on migrants is a move away from the universal principles on which it was founded. It brings us closer to the American model where certain people are denied care because of their inability to pay.

More information available from ***http://www.docsnotcops.co.uk/join***

£630m
Overall migrant annual **contribution** to UK economy

£10m - £2bn
Range of government claims for cost of **'health tourism'**

0.3%
maximum share of NHS budget taken by 'health tourism', according to research by 'New Statesman' magazine.

Growing list of treatments you may find excluded

Research last year for the Press Association and ITV found rationing was already rife across the NHS, including even cuts to cancer treatments, costly medicines, mental health services and knee and hip replacements.

Seventy percent of 1,039 doctors surveyed said they had witnessed restrictions to NHS services and treatments in the past year.

Most (84%) said this was happening for financial reasons, while the second most common cause was NHS managers wanting to "manage" patient demand – a common phrase in almost all of the 44 Sustainability and Transformation Plans across England.

Common clampdowns include cutting access to breast reductions, varicose vein removal, IVF, and the removal of benign lumps and bumps.

Almost one in four (23%) doctors said they had witnessed "drug rationing", with some of the most common rationing occurring for cancer drugs, but also for painkillers and arthritis medicines.

Other services have been stopped because they are no longer supported by clinical evidence.

Two-thirds of doctors said restrictions increased the chance a patient would need to go private: almost all (94%) doctors said more rationing was inevitable, given rising demand and tight finances.

Dr Mark Porter, chairman of the BMA, said: "The rationing of vital health care not only causes delay and distress to patients, but can end up costing the NHS more money in the long run."

Prescription charges – a tax on the sick

The vast majority (over 90%) of prescriptions are dispensed free of charge – for over-60s, children and under 18s in full time education, for pregnant women till a year after birth, for those on benefits and low income, and a few chronic medical conditions.

But the prescription charge in England, that has just risen to £8.60 per item, is a potentially punitive cost for people working on low pay, who may well also suffer long term illness.

The income from prescriptions is well short of even 1 percent of the NHS budget in England: but while it raises little it is likely to deter many from seeking advice and accessing the treatment they need.

An NHS that was genuinely committed, as it claims to be, to developing proactive health care that could prevent the onset of more serious conditions would be seeking ways of making prescriptions free for all, as the devolved governments have done in Wales, Scotland and Northern Ireland, rather than looking for ways to force the sick and elderly to pay.

Where can health campaigners have most impact?

Marginal seats and local STPs

England's NHS is currently divided up into 44 "footprint" areas, each of which had to develop a 5-year "Sustainability and Transformation Plan" (STP) last year.

The STPs have the task of improving health while wiping out trust deficits and delivering huge "efficiency savings" which in many areas include cuts in beds, downgrading or closure of A&E units and cuts in staff.

Up to now, with some exceptions, MPs in these areas have largely stood by while local services are threatened: now is a chance to put candidates from all parties on the spot. You could use our petition (see centre pages or *www.healthcampaignstogether.com*) to see if they will sign up to fight on for local access to care after June 8. Publicise their response.

Our non-party guidance is simple: ONLY VOTE for candidates who you believe to be WILLING TO FIGHT FOR LOCAL NHS SERVICES.

Constituency	STP area	Result	Second Party	Majority 000s
Barrow and Furness	Lancashire and South Cumbria	Lab hold	Con	**795**
Bedford	Bedfordshire Luton & Milton Keynes	Con hold	Lab	**1097**
Bolton West	Greater Manchester	Con gain from Lab	Lab	**801**
Brentford and Isleworth	North West London	Lab gain from Con	Con	**465**
Brighton, Kemptown	Sussex and East Surrey	Con hold	Lab	**690**
Bury North	Greater Manchester	Con hold	Lab	**378**
Cambridge	Cambridgeshire and Peterborough	Lab gain from LD	LD	**599**
Carshalton and Wallington	South West London	LD hold	Con	**1510**
City Of Chester	Cheshire and Merseyside	Lab gain from Con	Con	**93**
Croydon Central	South West London	Con hold	Lab	**165**
Derby North	Derbyshire	Con gain from Lab	Lab	**41**
Dewsbury	West Yorkshire	Lab gain from Con	Con	**1451**
Ealing Central and Acton	North West London	Lab gain from Con	Con	**274**
Eastbourne	Sussex and East Surrey	Con gain from LD	LD	**733**
Enfield North	North Central London	Lab gain from Con	Con	**1086**
Halifax	West Yorkshire	Lab hold	Con	**428**
Hampstead and Kilburn	North Central London	Lab hold	Con	**1138**
Hove	Sussex and East Surrey	Lab gain from Con	Con	**1236**
Ilford North	North East London	Lab gain from Con	Con	**589**
Lancaster and Fleetwood	Lancashire and South Cumbria	Lab gain from Con	Con	**1265**
Lewes	Sussex and East Surrey	Con gain from LD	LD	**1083**
Lincoln	Lincolnshire	Con hold	Lab	**1443**
Morley and Outwood	West Yorkshire	Con gain from Lab Coop	Lab	**422**
Newcastle-Under-Lyme	Staffordshire	Lab hold	Con	**650**
North East Derbyshire	Derbyshire	Lab hold	Con	**1883**
Peterborough	Cambridgeshire and Peterborough	Con hold	Lab	**1925**
Plymouth, Moor View	Devon	Con gain from Lab	Lab	**1026**
Plymouth, Sutton and Devonport	Devon	Con hold	Lab	**523**
Southport	Lancashire and South Cumbria	LD hold	Con	**1322**
Telford	Shropshire and Telford and Wrekin	Con gain from Lab	Lab	**730**
Thornbury and Yate	Bristol, North Somerset and S. Gloucs	Con gain from LD	LD	**1495**
Twickenham	South West London	Con gain from LD	LD	**2017**
Walsall North	Black Country	Lab hold	Con	**1937**
Weaver Vale	Cheshire and Merseyside	Con hold	Lab	**806**
Westminster North	North West London	Lab hold	Con	**1977**
Wirral West	Cheshire and Merseyside	Lab gain from Con	Con	**417**
Wolverhampton South West	Black Country	Lab gain from Con	Con	**801**
Wrexham	Cheshire and Merseyside	Lab hold	Con	**1831**

Most STPs lack serious plan for workforce

Two-thirds of the published STP plans (30/44) have no detailed workforce plan to ensure an adequate workforce will be in place to implement the policies and new services they outline.

Three STPs claim that a plan exists, but they have not published it: four more at least offer some data on local workforce issues, but this falls well short of offering any coherent or practical plan.

Another seven are seeking to make substantial savings from workforce budgets, and/or reduce the numbers of staff employed.

Not one STP even mentions the looming threat of Brexit, which is already beginning to impede recruitment of professional staff from within the EU.

This will intensify in impact now that the government has refused to guarantee that an estimated 50,000 professional staff and doctors from throughout Europe will be able to remain in the UK.

Nor is there any serious engagement with the problems of recruitment of student nurses following the government's decision to scrap the successful NHS bursary scheme that helped cover the costs for adult entrants.

23%
Fall in applications for **nurse training** since NHS bursaries scrapped

90%
Fewer applications from **EU nurses** to work in the NHS since the Brexit vote

24,000
Number of unfilled **nurse vacancies**

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